MPW Recert Checklist

- ☐ Team Sign In Sheet
- ☐ MAP 116
- ☐ MAP 531
- ☐ PDS Rights, Responsibility, and Risk (RRR)
- ☐ PDS Employer Responsibilities and Expectations (ERE)
- ☐ PDS Representative Training
- ☐ PHI
- ☐ Employee Contracts (If updates are needed)
- ☐ PDS Employee Training
- ☐ Grievance Policy
- ☐ MAP 2000
- ☐ Participant Summary
- ☐ Hospitalization and Medicaid Fraud
- ☐ Medicaid Waiver Telehealth Policy
- ☐ Rep Abuse Neglect and Exploitation
- ☐ Rep Fraud Waste and Abuse
- ☐ Employee Abuse Neglect and Exploitation
- ☐ Employee Fraud Waste and Abuse
- ☐ KIPDA PDS Program EVV Guidelines (All Employees)

MPW Basics:101

Max pay rates: PC-$36.32, CLS-$26.80 (these rates are for non-taxed employees including parent, spouse or child under 21). Taxed employees rates are a few dollars less per hour (use pay rate calculator)

Respite: 1312 units yearly. Max pay rates: $23.68 (this rate is for non-taxed employees including parents, spouse, or child under 21). Taxed employee rates are a few dollars less per hour (use pay rate calculator).

Max MPW annual PDS budget – Currently there is no maximum set budget, the budget is determined based on the highest pay rates for each service

Max weekly hours: 40 hours weekly-all service combined *(excluding Respite).*

Note - No single employee can work more than 40 hours weekly.

PDS Service definitions/billing codes:

T1005:HI Respite – Maintain safety and general well-being of participant on a temporary basis in absence of primary caregiver. Assist with all ADL's and IADL's as needed while monitoring for safety. *(can be provided anywhere-if client remained safe and healthy throughout a Respite shift, the goal should always be "Maintained" on the timesheet.)*

T1019:HI Personal Care (PC) – Hands on assistance (HOA) with all Activities of daily Living (ADL's) including: dressing/undressing, grooming, mobility, bathing, toileting, eating/feeding/specialized meal prep, transferring, ambulation, and medication management. (*This must be provided primarily in the home. PC is something that must be done every day for the HSW of participant and it is NOT goal oriented. If a PC task is completed adequately during a shift the goal should always state "Maintained".*

97535:HI Community Living Support (CLS) – 1:1 service provided for both children and adults which facilitates independence and promotes community participation/inclusion. This service is designed to allow individuals residing in their own home or their family's home to have fun in life and learn skills that connect them to helpful resources and their community. CLS is "goal oriented" and should directly relate to the individual's goals listed on the POC. All CLS goals should clearly exceed that of his or hers aged matched peers. (Ex-a young child should not have "transportation" listed as a goal since a child under the age of 16 would not be driving or utilizing public transportation regardless of that child's diagnosis.) All goals should be person-centered, obtainable, and measurable. Goals can and should indicate specific reasons as to why the participant "*maintained, regressed, or progressed*" during any shift worked.

Other/Traditional Supports:

Adult Day Training
Training in ADLs, self-advocacy, and adaptive and social skills to support participation in daily, meaningful routines of the community. May include work-like settings that do not meet the definition of supported employment for adult participants

Behavior Support Service
Behavior support services are the systematic application of techniques and methods to influence or change a behavior in a desired way. The service shall be provided to assist participants to learn new behaviors or functionally equivalent replacement behaviors for identified challenging behaviors.

Occupational Therapy, Physical Therapy, and Speech Language Pathology Services
Often, a participant may qualify for these services through Medicaid directly, but if not, they can be requested on their Michelle P Waiver.

Supported Employment
Assistance and training in obtaining paid, competitive employment at or above minimum wage for participants who have been demonstrated inability to gain or maintain tradition employment. A participant will first need to apply for support through Vocational Rehab. After resources through Voc Rehab are exhausted, then they may apply for supported employment through Michelle P Waiver.

Environmental & Minor Home Adaptation Service (up to $605 a year)
Adaptations designed to enable participants to interact more independently with their environment thus enhancing quality of life and reducing dependence on support from others

EMERGENCY BACK UP PLAN

WHO:

Name, Relation, and contact number for each backup care provider:

_____

_____

_____

WHAT:

What services does the participant need help with that, if not received, would pose a risk to their health, safety, and welfare needs? Usually those are the tasks listed on the Plan of Care for Attendant Care or Personal Care. List those services and who will provide them:

_____

_____

_____

_____

_____

Does the participant have a preference as to who provides which service?

_____

_____

WHEN:

How long can the participant safely be without services?

_____

OTHER IMPORTANT CONSIDERATIONS:

Is the participant utility dependent? Do they require electricity for life saving devices? Do they require refrigeration for medications? Do they have a generator?

_____

_____

_____

What are the participant's preferences and requirements for evacuation during a natural or other disaster? Is the participant bedbound and living alone and do the fire department, landlord, and police need to be notified as part of a safety plan?

_____

_____

_____

If the participant attends an Adult Day Health program, do they have a backup plan if the agency were to unexpectedly close?

_____

_____

_____

TEAM SIGN IN SHEET

Indicates who was present from the Plan of Care Meeting

- PDS Representative to sign on indicated areas
- Client and/or any other relevant parties to sign who where part of the meeting
- Ask CM for clarification

Person Centered Team Sign-in Sheet

Team Meeting Date:	

Participant Name: Last:		First:		SSN:		Medicaid Number:	

Full Name	Signature	Title	Date	Your Role in Participant's life/ Relation to Participant	How long have you known the participant?	Provider Agency (if applicable)	Email (if applicable)
		Representative				—	—

If attendance is via an electronic method, it is the responsibility of the attendee to submit an email to the case manager to serve as record of their participation and agreement in the development of the person centered service plan. The case manager must upload these email confirmations along with the sign in sheets when submitting the person centered service plans to MWMA.

MAP-116

Provides authorization for Participants Plan to be shared on MWMA.

*Required

- Review and check each box
- Print first and last name of **CLIENT**
- PDS Representative to sign

MAP – 116
(05/2015)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Service Plan – Participant Authorization

Participant

- ☐ I give approval to share the service plan
- ☐ I, my Authorized Representative, and/or Legal Guardian have signed the Service Plan signature sheet
- ☐ I certify that I and/or my Legal Representative have been informed of waiver services
- ☐ I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid services
- ☐ I certify that I have made an informed choice when selecting services and supports and the providers/employees to provide each service, as well as the setting of each service

First Name _____ Middle Initial _____ Last Name _____

Signature _____ Date: _____

MAP 531

Shows proof that services provided are conflict free. KIPDA is only providing case management and financial management.

- CM to fill out participant information
- Middle box leave empty (only check if requesting a conflict exemption)
- PDS Rep to sign and date for participant. Legal guardian to sign in addition to, if applicable.
- Ask CM for clarification

MAP 531
(10-2015)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

CASE MANAGEMENT CONFLICT EXEMPTION

Conflict-Free Case Management requires that a waiver provider (including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider) who renders case management to an individual, must not also provide another waiver service to that same individual, unless the provider is the only willing and qualified provider in the geographical area (30 miles from the participant's residence). To request an Exemption based on geographical area, you must upload an electronic copy of this completed form to the Medicaid Waiver Management Application (MWMA). The Department must approve Exemptions.

Participant Information:

Last Name:	First Name:	M.I.:	SSN #:
Address (Street):			
City:	State:	ZIP:	County Name:
Current Case Manager: Last		First Name:	
Case Manager Email:			

Complete the following if requesting a Conflict-Free Case Management Exemption:

I request an exemption to Conflict-Free Case Management because:

☐ There is a lack of qualified case managers within thirty (30) miles of my residence; Explain:

-I certify that my decision to keep my current case manager was not encouraged by the case manager or other staff from the case management agency.

-I have been informed of grievance/complaint procedures.

Participant/Guardian Signature:		**Date:**	
Case Manager Signature:		**Date:**	

By electronically signing and dating this document, the Case Manager verifies that the Participant/Guardian agrees with the information contained on both pages of this form and has electronically signed this document or if not, has signed a paper copy which is kept with the participant's service records.

CLEAR FORM

PDS RIGHTS, RESPONSIBILITY, AND RISK

Reviews basic RRR to the Participant Direct Service Option under HCBS Waiver programs.

- Review form with CM
- PDS Rep to sign in indicated spot for participant
- Legal guardian to sign second line if applicable
- A copy is included for you to keep

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living & Department for Medicaid Services

PARTICIPANT DIRECTED SERVICES
RIGHTS, RESPONSIBILITIES, AND RISKS STATEMENTS

I understand that I have the **RIGHT** to:

- Choose whether an authorized service will be provided by a traditional waiver provider or through Participant Directed Services (PDS);
- Work with my support broker in developing my plan of care and support spending plan;
- Have a monthly face-to-face visit with my support broker and be informed of the balance remaining in my approved Participant Directed Services budget; and
- Contact a support broker twenty-four (24) hours per day and seven (7) days per week if a need or question arises.

I understand that I have the **RESPONSIBILITY** to:

- Be trained to coordinate my care and manage my budget prior to beginning PDS services;
- Participate in monthly face-to-face visits with my support broker;
- Work with my support broker to determine my natural supports (family and friends) who can assist me when my PDS services are not being provided;
- Hire and train employees who I trust to perform the services outlined on my plan of care;
- Work with my support broker to ensure my employees are cleared through the criminal background check, Kentucky Nurse Aide Registry, Kentucky Adult Caregiver Misconduct Registry, and Central Registry prior to starting services through PDS;
- Keep up with my employees' time and the services provided, and ensure timesheets and service notes are documented correctly before being submitted to my support broker;
- Stay within my approved PDS annual budget;
- Pay my monthly patient liability on time, if applicable; and
- Maintain my eligibility for Medicaid as long as I continue to meet eligibility requirements.

I understand that I have the **RISK** of being terminated from Participant Directed Services:

- If I fail to pay monthly patient liability;
- If I do not use Participant Directed Services within sixty (60) consecutive days;
- If I do not make appropriate decisions concerning Participant Directed Services and place the Participant's health, safety, and welfare in jeopardy;
- If I am non-compliant with the person-centered service plan;
- If I, any of the employees, family members, or guardian may threaten or intimidate a support broker or any other PDS staff; and
- If I over-spend or mismanage the approved Participant Directed Services budget.

As the Participant or designated representative choosing Participant Directed Services, I have read the above Rights, Responsibilities and Risks statements. I have had all my questions answered by my support broker, and I have received a copy of these statements from my support broker. I further understand that if I submit any false information to the Department that I am subject to criminal prosecution, jeopardize my Participant Directed Services eligibility, and will be required to return any benefits received.

Participant/Representative Signature	**Date**
Guardian	**Date**
Support Broker Signature	**Date**

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living & Department for Medicaid Services

PARTICIPANT DIRECTED SERVICES
RIGHTS, RESPONSIBILITIES, AND RISKS STATEMENTS

I understand that I have the **RIGHT** to:

- Choose whether an authorized service will be provided by a traditional waiver provider or through Participant Directed Services (PDS);
- Work with my support broker in developing my plan of care and support spending plan;
- Have a monthly face-to-face visit with my support broker and be informed of the balance remaining in my approved Participant Directed Services budget; and
- Contact a support broker twenty-four (24) hours per day and seven (7) days per week if a need or question arises.

I understand that I have the **RESPONSIBILITY** to:

- Be trained to coordinate my care and manage my budget prior to beginning PDS services;
- Participate in monthly face-to-face visits with my support broker;
- Work with my support broker to determine my natural supports (family and friends) who can assist me when my PDS services are not being provided;
- Hire and train employees who I trust to perform the services outlined on my plan of care;
- Work with my support broker to ensure my employees are cleared through the criminal background check, Kentucky Nurse Aide Registry, Kentucky Adult Caregiver Misconduct Registry, and Central Registry prior to starting services through PDS;
- Keep up with my employees' time and the services provided, and ensure timesheets and service notes are documented correctly before being submitted to my support broker;
- Stay within my approved PDS annual budget;
- Pay my monthly patient liability on time, if applicable; and
- Maintain my eligibility for Medicaid as long as I continue to meet eligibility requirements.

I understand that I have the **RISK** of being terminated from Participant Directed Services:

- If I fail to pay monthly patient liability;
- If I do not use Participant Directed Services within sixty (60) consecutive days;
- If I do not make appropriate decisions concerning Participant Directed Services and place the Participant's health, safety, and welfare in jeopardy;
- If I am non-compliant with the person-centered service plan;
- If I, any of the employees, family members, or guardian may threaten or intimidate a support broker or any other PDS staff; and
- If I over-spend or mismanage the approved Participant Directed Services budget.

As the Participant or designated representative choosing Participant Directed Services, I have read the above Rights, Responsibilities and Risks statements. I have had all my questions answered by my support broker, and I have received a copy of these statements from my support broker. I further understand that if I submit any false information to the Department that I am subject to criminal prosecution, jeopardize my Participant Directed Services eligibility, and will be required to return any benefits received.

Participant/Representative Signature	**Date**
Guardian	**Date**
Support Broker Signature	**Date**

EMPLOYER (REP) REPSONSIBILITES AND EXPECTATIONS

Reviews specific responsibilities of the Representative as it relates to the Participant Directed Service Option

- Review with CM
- Last page Rep print, sign, and date where indicated
- A copy is provided for your record

Participant Directed Services (PDS)

Employer Responsibilities and Expectations

As a participant or an appointed representative, you are in charge of services; you are to carry out employer related duties to ensure the program is being utilized properly. This form may serve as a guide for how you direct the program.

Responsibilities

Service Plan: The acting employer ensures the needs, goals, and duties follow Person Centered Principles. This means each duty and goal has been carefully considered and the participant's wishes and desires, and best interests are first and foremost. Should a need arise that has not been addressed in the service plan, you are responsible for identifying this with the case manager/service advisor to consider if changes are necessary. This enables you to have a basis for job expectations and job duties for employees you oversee.

Employees: There are several aspects regarding employees for which you need to be aware. Many of them are listed in this section.

Recruiting: You will be responsible for finding employees. You may find employees by many means, utilizing any internet sources, advertising on radio, newspaper, TV, flyers, word of mouth, or through organizations; it is your choice how you pursue employees.

Interviewing: It is highly advised each employee go through a screening process. Should you choose to interview candidates, it is recommended you determine the availability of the candidate, the experience the candidate may have with any vulnerable population, any education or training the candidate may have received, and skills that may be relevant to the job. It is highly advised you avoid questions pertaining to characteristics that are unrelated to job performance, such as religion, age, sexual orientation, as these can lead to discrimination claims.

Hiring: Candidates are required to complete an application, background checks, screenings, and trainings to be qualified. You are responsible as an Employer of Record for the fees associated with these qualifications.

Job Expectations: It is highly advised each employee be provided with a written or typed copy of job expectations and duties. These may include but not limited to: promptness, personal conduct while in the home/out in the community, how duties should be conducted for/ assisted with the participant, and others you feel are appropriate to the situation.

Disciplinary Action: In order to provide fairness to an employee, you should ensure you have a procedure in place for various events or causes of inadequate employment performance. It is highly advised you provide a written or typed copy of what warrants a verbal warning, a written warning, suspension, or termination of employment, or other means of disciplinary action. This provides clear instruction to the employee of your expectations, as well as supports you should unemployment claims be filed against you.

Authorizing Time: Your employees are responsible for submitting timesheets, including service documentation, for each day services are provided. You are responsible for authorizing that services were performed to your satisfaction, as well as meeting the terms of the service plan. Should you disagree with the hours performed or the statements of the duties provided, you should speak with your employee immediately to determine if revisions can be agreed upon. Should an agreement not be reached, you may need to consult with the Department of Labor to resolve the situation.

Employee Requirements: Before employees can begin under PDS, the following requirements must be completed:

Criminal Record Check: The Administrative Office of the Courts (AOC) is the only required criminal background check for employees. The fee is twenty ($20) dollars. An employee is prohibited from employment through PDS if results reveal a conviction specified in the waiver's respective regulation. You as an employer may decide to move forward with a potential employee if other convictions are revealed in those results.

Nurse Abuse Registry: An employee must have results of a check from the Nurse Abuse Registry; this may be completed online through the Kentucky Board of Nursing. Your case manager/service advisor may complete this check using any known names of the employee. If results reveal the employee is identified as being on the registry, the employee is prohibited from employment through PDS.

Kentucky Adult Caregiver Misconduct Registry: An employee must have results from the Kentucky Adult Caregiver Misconduct Registry. The check can be done online and not show any results. If any results are shown, then that employee is not eligible to work.

Central Registry Check: This is a requirement for employees with participants on all waivers. Results will be sent to the case manager/service advisor agency. The fee is ten ($10) dollars. This check must be completed before starting employment for MPW (or within thirty (30) days of starting employment for ABI-A, ABI-LTC, HCB or SCL waivers); should results not return within that timeframe, the employee is considered suspended from PDS payment until results are obtained. If results reveal the employee is identified as being on the registry, the employee is prohibited from employment through PDS.

***Note**: Your employee may need to complete an out-of-state equivalent to these background checks if the potential employee has lived or worked outside the state of Kentucky within the last year.

Training: An employee is required to complete specific trainings; this depends upon which waiver for which you are enrolled. Your case manager/service advisor will guide you on what the trainings are, when they are due, and if they need to be renewed.

Screenings: Tuberculosis (TB) screening and a drug screening may be required; this depends upon which waiver you are enrolled in. Your case manager/service advisor will guide you on whether these are required, when they are due, and if they need to be renewed.

Annual Budget: A participant is able to access a dollar amount or units of service, expressed in hours, as long as medical Level of Care is met, Financial Eligibility is maintained and a prior authorization is active. This authorization may be renewed annually. The authorization is used to cover employees' wages for hours worked, and employer taxes incurred. A dollar amount may be requested to set aside for Goods and Services if necessary. Additional funding may be necessary to cover the care that is not addressed in the service plan; speak with a case manager/service advisor to further understand these circumstances.

Employer Taxes: As an Employer of Record, you are responsible to the federal, state, and local government for any taxes associated with operating a business with employees. Your case manager/service advisor works in close connection with the Financial Management Agent (FMA) to provide detailed information about what dollars are submitted for federal and state unemployment taxes, FICA (Federal Insurance Contributions Act), and any local taxes associated with a city or county for which the participant resides. The FMA will express these taxes in a percentage that is added to the employees' wages as they submit timesheets. Percentages vary across the state depending on the participant's circumstance and changes in state and federal law, but the typical percentage is around 11.30% (this percentage is tacked on to every dollar utilized for employees' wages for billing through the FMA). This percentage can change annually, depending on any changes in federal tax laws; be aware these potential changes in federal tax will impact the amount of dollars you have available for employees from year to year. Because where you live may impact this percentage, the FMA will determine the exact percentage as part of your budget.

Unemployment awarded to any employee through a formal dispute of termination will increase your state unemployment tax rate, reducing the amount of dollars available for services fulfill the service plan, and possibly reducing the maximum wage payable to employees. It is highly advised to review the Job Expectations, Disciplinary Action, and Authorizing Time sections of this form to minimize the risk of this increase.

Services Available: The enrolled waiver has services defined in a very specific manner to meet your needs. Each of these services has a limit as to how many dollars can be accessed per hour, along with other limits as to how the service can be accessed. It is best to know what is available that may be at your disposal to best provide care. Your case manager/service advisor is available to provide details of these services.

Wages Available: As required by the Federal Labor Standards Act, you must offer employees a minimum of $7.25 per hour; be aware this may change in the future. You must also be aware of the highest dollar amount you can provide, as described in the last section, each service has a different limit. The wage limit you provide may be influenced by employer tax rate that is mentioned above in the section **Employer Taxes**.

Hours Worked: You are in charge of setting times for when your employees are scheduled to work. It is best practice to work with an employee to schedule at least one (1) week ahead of time. Should scheduling need to change, it is also best practice to notify any changes to that schedule immediately, as unexpected or repeated disruptions can lead employees to search for employment elsewhere due to unpleasant working conditions. It is best to stay informed with your case manager/service advisor at least monthly to have a strong understanding of hours you have available for the following weeks and months, as well as understand how are hours are being spent among your employees.

An example in motion:

For MP, ABI, and ABI-LT participants only. You've got an employee set up, and you have a budget, but how does this work? A key factor in this process is always keeping in mind that, if you increase pay rate, or if tax rate increases, you will have to reduce your hours in order to remain within the issued annual budget. The same thing applies for the amount of hours worked; if you increase the amount of hours, you must decrease the pay rate of employees in order to stay within the issued annual budget.

You have an employee assigned at $10.00 per hour; your annual budget is $4,000.00; the case manager/service advisor has informed you that your employer tax rate is 11.24%; so how many hours can you have your employee work?

Since we have to designate 11.24% toward employer taxes, you must set aside $449.60 for these taxes over the course of the year. This leaves your participant with $3,550.40 to utilize yearly. Over 12 month span, a participant would average $295.86 worth of services toward this employee. At $10.00 per hour, the participant would have 29.5 hours of services on average per month..

Expectations

Communication and Attendance:

As the acting employer, you are considered the employer of record, therefore you have direct oversight of the employees and the responsibility of ensuring the service plan is followed. Should questions arise by the FMA or the case manager/service advisor, they will be expecting you to answer questions about the program operations or about an employee. Employees should only be bringing business concerns to you and not to the case manager/service advisor or the FMA. You must communicate well with your case manager/service advisor in order to establish and maintain fluid operation of PDS.

As a participant or as a representative, you are required to meet with a case manager/service advisor for a face to face visit to discuss how services are being performed. The case manager/service advisor will inform you of how often you need to meet, and what locations are acceptable. Failure to do so can lead to termination from the program.

Program Integrity:

A participant may be subject to disciplinary action within the program for various reasons. You have the responsibility to understand what may warrant a Corrective Action Plan (CAP) so that services are not in jeopardy of being lost in the home. Examples can be: Not following the service plan; failure to pay patient liability; a participant, family member, employee, or other person threatening or intimidating a case manager/service advisor or other program staff; the participant needs more care than the program can provide; prohibiting the case manager/service advisor or other staff from performing regulatory requirements. It is highly advised to have a detailed conversation with your case manager/service advisor about these and other possible scenarios.

Please choose from either option below.

☐ I have read this Employer Responsibilities and Expectations statement. I shall be acting as my own employer. In the future I may choose to appoint a representative at any point in time to act on my behalf. Should I have questions regarding any of the topics referenced above, or other concerns, I will address them with the case manager/service advisor with whom I am working for clarification.

Participant's Signature	Date	Participant (print name)
Guardian's Signature	Date	Guardian (print name)
Case Mgr./Service Adv. Signature	Date	Case Mgr./Service Adv. (print name)

☐ I have read this Employer Responsibilities and Expectations statement. I choose to appoint the person named below to act on my behalf for all program decisions. In the future I may choose to change the appointed person at any point in time.

Representative's Signature	Date	Representative (print name)
Participant/Guardian's Signature	Date	Participant/Guardian (print name)
Case Mgr./Service Adv. Signature	Date	Case Mgr./Service Adv. (print name)

Participant Directed Services (PDS)

Employer Responsibilities and Expectations

As a participant or an appointed representative, you are in charge of services; you are to carry out employer related duties to ensure the program is being utilized properly. This form may serve as a guide for how you direct the program.

Responsibilities

Service Plan: The acting employer ensures the needs, goals, and duties follow Person Centered Principles. This means each duty and goal has been carefully considered and the participant's wishes and desires, and best interests are first and foremost. Should a need arise that has not been addressed in the service plan, you are responsible for identifying this with the case manager/service advisor to consider if changes are necessary. This enables you to have a basis for job expectations and job duties for employees you oversee.

Employees: There are several aspects regarding employees for which you need to be aware. Many of them are listed in this section.

Recruiting: You will be responsible for finding employees. You may find employees by many means, utilizing any internet sources, advertising on radio, newspaper, TV, flyers, word of mouth, or through organizations; it is your choice how you pursue employees.

Interviewing: It is highly advised each employee go through a screening process. Should you choose to interview candidates, it is recommended you determine the availability of the candidate, the experience the candidate may have with any vulnerable population, any education or training the candidate may have received, and skills that may be relevant to the job. It is highly advised you avoid questions pertaining to characteristics that are unrelated to job performance, such as religion, age, sexual orientation, as these can lead to discrimination claims.

Hiring: Candidates are required to complete an application, background checks, screenings, and trainings to be qualified. You are responsible as an Employer of Record for the fees associated with these qualifications.

Job Expectations: It is highly advised each employee be provided with a written or typed copy of job expectations and duties. These may include but not limited to: promptness, personal conduct while in the home/out in the community, how duties should be conducted for/ assisted with the participant, and others you feel are appropriate to the situation.

Disciplinary Action: In order to provide fairness to an employee, you should ensure you have a procedure in place for various events or causes of inadequate employment performance. It is highly advised you provide a written or typed copy of what warrants a verbal warning, a written warning, suspension, or termination of employment, or other means of disciplinary action. This provides clear instruction to the employee of your expectations, as well as supports you should unemployment claims be filed against you.

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Nurse Abuse Registry: An employee must have results of a check from the Nurse Abuse Registry; this may be completed online through the Kentucky Board of Nursing. Your case manager/service advisor may complete this check using any known names of the employee. If results reveal the employee is identified as being on the registry, the employee is prohibited from employment through PDS.

Kentucky Adult Caregiver Misconduct Registry: An employee must have results from the Kentucky Adult Caregiver Misconduct Registry. The check can be done online and not show any results. If any results are shown, then that employee is not eligible to work.

Central Registry Check: This is a requirement for employees with participants on all waivers. Results will be sent to the case manager/service advisor agency. The fee is ten ($10) dollars. This check must be completed before starting employment for MPW (or within thirty (30) days of starting employment for ABI-A, ABI-LTC, HCB or SCL waivers); should results not return within that timeframe, the employee is considered suspended from PDS payment until results are obtained. If results reveal the employee is identified as being on the registry, the employee is prohibited from employment through PDS.

***Note**: Your employee may need to complete an out-of-state equivalent to these background checks if the potential employee has lived or worked outside the state of Kentucky within the last year.

Training: An employee is required to complete specific trainings; this depends upon which waiver for which you are enrolled. Your case manager/service advisor will guide you on what the trainings are, when they are due, and if they need to be renewed.

Screenings: Tuberculosis (TB) screening and a drug screening may be required; this depends upon which waiver you are enrolled in. Your case manager/service advisor will guide you on whether these are required, when they are due, and if they need to be renewed.

Annual Budget: A participant is able to access a dollar amount or units of service, expressed in hours, as long as medical Level of Care is met, Financial Eligibility is maintained and a prior authorization is active. This authorization may be renewed annually. The authorization is used to cover employees' wages for hours worked, and employer taxes incurred. A dollar amount may be requested to set aside for Goods and Services if necessary. Additional funding may be necessary to cover the care that is not addressed in the service plan; speak with a case manager/service advisor to further understand these circumstances.

Employer Taxes: As an Employer of Record, you are responsible to the federal, state, and local government for any taxes associated with operating a business with employees. Your case manager/service advisor works in close connection with the Financial Management Agent (FMA) to provide detailed information about what dollars are submitted for federal and state unemployment taxes, FICA (Federal Insurance Contributions Act), and any local taxes associated with a city or county for which the participant resides. The FMA will express these taxes in a percentage that is added to the employees' wages as they submit timesheets. Percentages vary across the state depending on the participant's circumstance and changes in state and federal law, but the typical percentage is around 11.30% (this percentage is tacked on to every dollar utilized for employees' wages for billing through the FMA). This percentage can change annually, depending on any changes in federal tax laws; be aware these potential changes in federal tax will impact the amount of dollars you have available for employees from year to year. Because where you live may impact this percentage, the FMA will determine the exact percentage as part of your budget.

Unemployment awarded to any employee through a formal dispute of termination will increase your state unemployment tax rate, reducing the amount of dollars available for services fulfill the service plan, and possibly reducing the maximum wage payable to employees. It is highly advised to review the Job Expectations, Disciplinary Action, and Authorizing Time sections of this form to minimize the risk of this increase.

Services Available: The enrolled waiver has services defined in a very specific manner to meet your needs. Each of these services has a limit as to how many dollars can be accessed per hour, along with other limits as to how the service can be accessed. It is best to know what is available that may be at your disposal to best provide care. Your case manager/service advisor is available to provide details of these services.

Wages Available: As required by the Federal Labor Standards Act, you must offer employees a minimum of $7.25 per hour; be aware this may change in the future. You must also be aware of the highest dollar amount you can provide, as described in the last section, each service has a different limit. The wage limit you provide may be influenced by employer tax rate that is mentioned above in the section **Employer Taxes**.

Hours Worked: You are in charge of setting times for when your employees are scheduled to work. It is best practice to work with an employee to schedule at least one (1) week ahead of time. Should scheduling need to change, it is also best practice to notify any changes to that schedule immediately, as unexpected or repeated disruptions can lead employees to search for employment elsewhere due to unpleasant working conditions. It is best to stay informed with your case manager/service advisor at least monthly to have a strong understanding of hours you have available for the following weeks and months, as well as understand how are hours are being spent among your employees.

An example in motion:

For MP, ABI, and ABI-LT participants only. You've got an employee set up, and you have a budget, but how does this work? A key factor in this process is always keeping in mind that, if you increase pay rate, or if tax rate increases, you will have to reduce your hours in order to remain within the issued annual budget. The same thing applies for the amount of hours worked; if you increase the amount of hours, you must decrease the pay rate of employees in order to stay within the issued annual budget.

You have an employee assigned at $10.00 per hour; your annual budget is $4,000.00; the case manager/service advisor has informed you that your employer tax rate is 11.24%; so how many hours can you have your employee work?

Since we have to designate 11.24% toward employer taxes, you must set aside $449.60 for these taxes over the course of the year. This leaves your participant with $3,550.40 to utilize yearly. Over 12 month span, a participant would average $295.86 worth of services toward this employee. At $10.00 per hour, the participant would have 29.5 hours of services on average per month..

Expectations

Communication and Attendance:

As the acting employer, you are considered the employer of record, therefore you have direct oversight of the employees and the responsibility of ensuring the service plan is followed. Should questions arise by the FMA or the case manager/service advisor, they will be expecting you to answer questions about the program operations or about an employee. Employees should only be bringing business concerns to you and not to the case manager/service advisor or the FMA. You must communicate well with your case manager/service advisor in order to establish and maintain fluid operation of PDS.

As a participant or as a representative, you are required to meet with a case manager/service advisor for a face to face visit to discuss how services are being performed. The case manager/service advisor will inform you of how often you need to meet, and what locations are acceptable. Failure to do so can lead to termination from the program.

Program Integrity:

A participant may be subject to disciplinary action within the program for various reasons. You have the responsibility to understand what may warrant a Corrective Action Plan (CAP) so that services are not in jeopardy of being lost in the home. Examples can be: Not following the service plan; failure to pay patient liability; a participant, family member, employee, or other person threatening or intimidating a case manager/service advisor or other program staff; the participant needs more care than the program can provide; prohibiting the case manager/service advisor or other staff from performing regulatory requirements. It is highly advised to have a detailed conversation with your case manager/service advisor about these and other possible scenarios.

Please choose from either option below.

☐ I have read this Employer Responsibilities and Expectations statement. I shall be acting as my own employer. In the future I may choose to appoint a representative at any point in time to act on my behalf. Should I have questions regarding any of the topics referenced above, or other concerns, I will address them with the case manager/service advisor with whom I am working for clarification.

Participant's Signature	Date	Participant (print name)
Guardian's Signature	Date	Guardian (print name)
Case Mgr./Service Adv. Signature	Date	Case Mgr./Service Adv. (print name)

☐ I have read this Employer Responsibilities and Expectations statement. I choose to appoint the person named below to act on my behalf for all program decisions. In the future I may choose to change the appointed person at any point in time.

Representative's Signature	Date	Representative (print name)
Participant/Guardian's Signature	Date	Participant/Guardian (print name)
Case Mgr./Service Adv. Signature	Date	Case Mgr./Service Adv. (print name)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

Home and Community Based Services
Corrective Action Plan

Participant: JoAnna Weiss Guardian: NA Case Manager/ Service Advisor: Amber

Is participant in Participant Directed Services? (•) Yes ( ) No

State Issue:

JoAnna's PDS employee repeatedly contacts KIPDA to discuss EVV hours and payment issues.

Regulation/ Policy Violation:

The program representative is the employer of record for PDS services--not KIPDA. KIPDA is responsible for case management, program oversight, and third-party payroll processing.

It is KIPDA's policy that all communications regarding PDS employees EVV hours, pay, and related issues must go through the program representative. It is against KIPDA's policy for KIPDA staff to speak directly to PDS employees about these issues.

REPRESENTATIVE TRAINING FORM

This training certificate indicates as the PDS Rep you have received training on items listed. All topics discussed other then Fraud, Abuse, Neglect, and Exploitation are outlined in the Employer Expectations). You were provided a copy.

If you need training on Fraud, Abuse, Neglect, and Exploitation let CM know. We can provide you with information on each subject.

- PDS Representative to sign on indicated line
- Participant and/or guardian to sign if applicable. Ask CM for clarification

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living & Department for Medicaid Services

PARTICIPANT DIRECTED SERVICES
PARTICIPANT/REPRESENTATIVE TRAINING VERIFICATION

As the participant or designated representative, I certify that prior to direct services being initiated, I received training on:

- Principles of Self-Determination;
- Employee Contracts;
- Employee Background Checks;
- Timesheets;
- Budget Management Responsibilities;
- Person-Centered Planning;
- Fraud, Abuse, Neglect, and Exploitation;
- Corrective Action Plans;
- Potential Terminations; and
- Any additional topics required by my support brokerage agency, DAIL or DMS.

Participant Signature _____ **Date** _____

Representative Signature (if applicable) _____ **Date** _____

Support Broker Signature _____ **Date** _____

CLIENT PHI RELEASE

Indicates what parties are able to receive and share client protected health information.

- Review with CM
- Top line should read Client Name
- Places that should be listed include any traditional agencies listed on client's POC, DMS, DAIL, DCBS, MAINSL, Medicaid, Medical Providers.
- PDS Representative to sign on indicated line
- Legal guardian and/or participant to sign in addition to if applicable

AUTHORIZATION TO USE/SHARE
CLIENT PROTECTED HEALTH INFORMATION (PHI)

I, _____, authorize KIPDA to use and/or share with: any entity or organization that is involved in the continuity of care my KIPDA services. This includes, but isn't limited to, the following items from my Protected Health Information (PHI): financial data, case notes, medical records (history and physical), medication printout, photographs, and any other information that KIPDA requires that is associated with my services. Entities typically include (but aren't limited to): medical services, other community services, billing and financial management entities, government databases and others.

I understand that the purpose of using and/or sharing this information is for:
_____ Activation or continuation for any KIPDA program.
_____ Any consultation or discussion with authorized party regarding client's status or condition.
_____Other _____

I understand that I may inspect or copy my PHI prior to use and/or sharing.

I understand that I may refuse to sign this authorization, but it might inhibit or eliminate my ability to receive services connected to KIPDA.

I understand that KIPDA recommends encryption for any electronic communications that I choose to send with any private information or PHI.

I understand that I may revoke this authorization at any time, if requested in writing, to:
KIPDA-Attention JoAnna Weiss, MA
11520 Commonwealth Drive
Louisville, KY 40299

Exception:
1. If KIPDA has taken an action based on my authorization, or
2. Has obtained my authorization for the purpose of receiving reimbursement from a third party payer.

Unless previously revoked, this authorization shall expire upon termination of my KIPDA services.

I understand that when KIPDA uses and/or shares my PHI with a third-party payer, this will result in direct or indirect payment for services as follows: _____(list program).

I have received a copy of KIPDA's Notice of Privacy Practices.

I have read and understand this authorization:

_____
Individual Signing Authorization Date

If not signed by the client, specify basis for authority to sign:
____ Parent ____ Spouse
____ Personal Representative ____ Other _____

_____
Staff Signature Title Date Signed

EMPLOYEE CONTRACTS

A contract must be completed for each PDS employee. The contract indicates authorized services and pay rates.

- Review services and payrates with CM for each employee
- PDS Representative and employee to sign on page 2 where indicated
- Signature dates need to match

NOTE: "Employer" on page one, second line, is the clients name, not the Reps name.

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

I (*employee name*) _____, last four of Social Security Number_____ have agreed to work under the employment of *(employer name/waiver participant name)* _____ Medicaid ID_____.

I understand that, as a waiver participant, I can choose a PDS representative to help me with my responsibilities as an employer.

Participant Directed Services Representative Name (if applicable) _____.

Financial Management Agency Name _____.

Case Manager Agency Name _____.

Services delivered under this contract will consist of the following:

Service Provided	Service Code	Rate Per Hour	Hours Per Week	Anticipated Start Date*	End Date**

**Anticipated start date should reflect the date services are anticipated to begin.*
*** Only complete end date if the employee stops providing the service.*

Please see the attached list for a list of services available via PDS. For a full waiver service listing and max rates, please see the Home and Community Based Services Waiver Rates document on https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

As the employee:

- ☐ I agree to provide the services as specified by my employer (the waiver participant) as defined in the table above.
- ☐ I understand civil or criminal penalties can be pursued and termination from employment can occur if allegations of fraud against the Department for Medicaid Services are substantiated.
- ☐ I understand that I shall not be allowed to provide services based on the results of my background check, all applicable screenings and/or failing to complete trainings/certifications required by my employer (the waiver participant).
- ☐ I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers Compensation (KRS Chapter 342) shall not apply to my employment as a PDS employee. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor case manager can be held liable for any injuries or losses I may incur while providing services.
- ☐ I understand that I must maintain employee/employer confidentiality.
- ☐ I understand this is an at-will contract and either party may terminate this agreement at any time.
- ☐ I understand that I must notify my employer (the waiver participant) of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.
- ☐ I agree to follow all relevant state and federal statutes and regulations, including the use of Electronic Visit Verification.
- ☐ I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer (the waiver participant) and myself.

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

As the employer (waiver participant):

- ☐ I understand that I may be responsible for wages for my employee should my employee or I not provide employee qualifications by the respective deadlines.
- ☐ I understand that I can only require my employee to assist with duties that are relevant to my needs and outcomes that are specified on the Person-Centered Service Plan for Medicaid payment.
- ☐ I understand that I may be responsible for payment for any hours I may require my employee to work beyond any prior authorization limits or waiver regulation guidelines.

Employee Signature Date

Employer/Participant Date

PDS Representative (if applicable) Date

Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

Waiver Services Available via PDS		
Waiver Program	**Service**	**Code**
ABI Acute	Companion	S5135 HI
ABI Acute	Personal Care	97535 HI
ABI Acute	Respite	T1005 HI
ABI Acute	Supported Employment	H0039 HI
ABI LTC	Community Living Supports	97535 HI
ABI LTC	Respite	T1005 HI
ABI LTC	Supported Employment	H0039 HI
HCB	Attendant Care	S5108 HI
HCB	Non-specialized Respite	T1005 HI
MP	Attendant Care	S5125 HI
MP	Community Living Supports	97535 HI
MP	Homemaker	S5130 HI
MP	Personal Care	T1019 HI
MP	Respite	T1005 HI
MP	Supported Employment	H0039
SCL	Community Access	97535 HI
SCL	Community Access Group	97537 HI
SCL	Community Guide	H2015 HI
SCL	Personal Assistance	T1019 HI
SCL	Respite	T1005 HI
SCL	Supported Employment	T2019 HI

EMPLOYEE TRAINING VERIFICATION

Training form indicating that the PDS employee has received training from the PDS Representative on items listed. If you need additional information on any indicated topic, please inform CM.

- PDS Representative to sign on indicated line.
- Employee to sign top line
- Dates need to match

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living & Department for Medicaid Services

PARTICIPANT DIRECTED SERVICES
EMPLOYEE TRAINING VERIFICATION

As a chosen employee, I certify that prior to direct services being initiated, I received training from my employer or in the presence of my employer on:

- Principles of Self-Determination;
- Employee Contracts;
- Employee Background Checks;
- Timesheets;
- Person-Centered Planning;
- Fraud, Abuse, Neglect, and Exploitation; and
- Any additional topics required by my support brokerage agency, DAIL, DMS or employer.

Employee Signature	**Date**
Participant/Representative/Employer Signature	**Date**
Support Broker Signature (if applicable)	**Date**

KIPDA Grievance Policy

Showing proof that you as the PDS Rep have been informed of KIPDA's grievance policies and protocols.

- Review with CM
- Rep to print, date, and sign back page
- A copy is provided for your records and/or grievances

Area Agency on Aging and Independent Living
Area Development District
Metropolitan Planning Organization

KIPDA

KIPDA's Division of Social Services GRIEVANCE POLICY

KIPDA Area Agency on Aging and Independent Living's (AAAIL) Waiver Program is committed to providing quality and effective services at the highest level to all clients served. In order to accomplish this commitment, clients and/or their representatives must have the opportunity to provide information to KIPDA concerning its experience with staff and services whether through comments, complaint, grievance or other method. The KIPDA Grievance Policy and Procedure is created and provided to each client for the purpose of providing a system for addressing issues and concerns that cannot be resolved informally between the client and staff.

What is a Grievance?

A grievance is a client complaint or expression of dissatisfaction regarding service delivery or treatment by staff. It is an expression of concern about any particular issue thought to be unjust, unfair or abusive. Filing a complaint means putting in writing anything you have experienced that you think was harmful, unfair, or not done correctly. All clients served by KIPDA AAAIL/WAIVER Program have a right to file a grievance.

Grievance Policy:

All clients and/or their representative have the right to file a formal complaint regarding services provided by KIPDA AAAIL/WAIVER Program and will not be denied these services based upon such complaints. All clients and/or their representative will receive the Grievance Policy during the initial care plan meeting and if necessary, KIPDA AAAIL/WAIVER Program staff will read and/or explain the policy and the client's right to file as well as process for filing a grievance.

The KIPDA AAAIL/WAIVER Program grievance procedure is intended to address only issues specific to the services of this program. The program is not expected to address complaints lodged by one client in reference to another client's issues; neither is it expected to address complaints regarding other agencies or external programs.

Clients and/or their representative will file or report a complaint/concern with the KIPDA AAAIL/ the Waiver Program Service Advisor/Case Manager, the Waiver Program Supervisor, the HCBW Program Coordinator or the KIPDA Quality Management Planner. The KIPDA AAAIL staff engaged will send the client a Grievance Form to be completed and sent back to the agency, addressed to the KIPDA Quality Management Planner within 10 days of receipt. Once the form has been received KIPDA's Director of Social Services will send the client a letter acknowledging receipt of the client's Grievance Form.

The client and/or their representative will also be informed that accompaniment by an advocate (e.g., co-worker, friend, family member, etc.) at each step of the grievance process is permissible and that the complaint may be withdrawn by the client at any time.

Grievance Procedures:

1. Client and/or their representative express complaint to KIPDA AAAIL/Waiver Program staff and is provided a KIPDA Grievance & Complaint Form.

11520 Commonwealth Drive
Louisville, KY 40299
www.kipda.org

Phone: 502.266.6084
Fax: 502.266.5047
TDD: 1.800.648.6057

HELPING GROW 9 COUNTIES ACROSS KENTUCKIANA

a. KIPDA Staff will provide client and/or their representative with a KIPDA Grievance & Complaint Form.
b. Staff will inform client and/or their representative of the process for completing and submitting the KIPDA Grievance & Complaint Form.
c. Staff will assist client and/or their representative with completing the form if assistance is requested.
d. Client will submit the Grievance & Complaint Form to the KIPDA Quality Management Planner as indicated on the Grievance Form within ten days of receipt of the Grievance & Complaint Form.
e. Quality Assurance Manager will record the complaint in the Grievance Logbook.

2. Upon receipt of the Grievance & complaint Form, a letter will be provided to the client officially acknowledging receipt of complaint and providing client with the option for a local resolution.
    a. The letter will provide the client and/or their representative the opportunity to first review the issue at the local level in a local resolution conference.
    b. The letter will include a proposed local resolution conference date and time.
    c. If the date and time is a conflict for the client, KIPDA will work with the client to schedule a time that works for both parties.
3. The Local Resolution Conference is the first level for the Grievance and will be conducted by the Executive Director of KIPDA or his designee.
    a. The Executive Director or their designee will serve as facilitator for the Local Resolution meeting.
    b. KIPDA, the client, and/or their representative will attempt to resolve the grievance and will include as appropriate:
        i. internal resources, such as staff involved;
        ii. External resources, such as personal advocacy groups.
    c. Upon conclusion of the Local Resolution Conference, a report will be prepared within five working (5) days from the date of the meeting summarizing the results of the conference and decision rendered by the Local Resolution Facilitator.
    d. If the participant is not satisfied with the resolution, he/she may request a second level review with or without legal representation.
4. The second level review must be requested within 30 days from receiving result of local resolution decision by completing the grievance and complaint form, which will be attached to the resolution meeting decision letter. The grievance and complaint form must be addressed to: KIPDA AAAIL Quality Management Planner, 11520 Commonwealth Drive, Louisville, KY 40299 or request a secure link to joanna.weiss@kipda.org.
    a. The second level review will be a formal review utilizing the agency's Executive Director and/or his designee, and two professional staff not involved in the program; or the KIPDA Aging and Disability Advisory Council Review Committee.
    b. The client will indicate on the Grievance and Complaint form how they want the second level review to be processed.
    c. The second level review will occur within 14 days of receipt of the request.
    d. Formal response of results of the second level review will be provided within five (5) days from the date of the review.

5. If the participant chooses they may, at any time, file a grievance or complaint with the Cabinet for Health and Family Services Ombudsman by contacting the Ombudsman office at 1-800-372-2937 or 1-800-627-4702.

I hereby certify that I have received and reviewed the following Grievance Policy Statement for the Waiver program participants.

I acknowledge these policies as a condition of the program and services at KIPDA. I understand I can contact KIPDA staff if I have any questions about these policies.

Name (print clearly):_____

Date: _____

Signature: _____

Area Agency on Aging and Independent Living
Area Development District
Metropolitan Planning Organization

KIPDA

KIPDA AAAIL/Waiver Program
Grievance & Complaint Form

Date_____

Client Name_____

Representative Name_____

Address_____

Phone Number_____

E-Mail Address_____

Nature of Complaint_____

_____

_____

_____

_____

_____

_____

Proposed
Resolution_____

_____

_____

Client/Representative Signature_____

Date_____

Send Form To: Quality Management Planner
KIPDA AAAIL/ADRC
11520 Commonwealth Dr, Louisville, KY 40299
Request encrypted email link to send at joanna.weiss@kipda.org

Area Agency on Aging and Independent Living
Area Development District
Metropolitan Planning Organization

KIPDA

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Grievance Policy:

All clients and/or their representative have the right to file a formal complaint regarding services provided by KIPDA AAAIL/WAIVER Program and will not be denied these services based upon such complaints. All clients and/or their representative will receive the Grievance Policy during the initial care plan meeting and if necessary, KIPDA AAAIL/WAIVER Program staff will read and/or explain the policy and the client's right to file as well as process for filing a grievance.

The KIPDA AAAIL/WAIVER Program grievance procedure is intended to address only issues specific to the services of this program. The program is not expected to address complaints lodged by one client in reference to another client's issues; neither is it expected to address complaints regarding other agencies or external programs.

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The client and/or their representative will also be informed that accompaniment by an advocate (e.g., co-worker, friend, family member, etc.) at each step of the grievance process is permissible and that the complaint may be withdrawn by the client at any time.

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    a. The Executive Director or their designee will serve as facilitator for the Local Resolution meeting.
    b. KIPDA, the client, and/or their representative will attempt to resolve the grievance and will include as appropriate:
        i. internal resources, such as staff involved;
        ii. External resources, such as personal advocacy groups.
    c. Upon conclusion of the Local Resolution Conference, a report will be prepared within five working (5) days from the date of the meeting summarizing the results of the conference and decision rendered by the Local Resolution Facilitator.
    d. If the participant is not satisfied with the resolution, he/she may request a second level review with or without legal representation.
4. The second level review must be requested within 30 days from receiving result of local resolution decision by completing the grievance and complaint form, which will be attached to the resolution meeting decision letter. The grievance and complaint form must be addressed to: KIPDA AAAIL Quality Management Planner, 11520 Commonwealth Drive, Louisville, KY 40299 or request a secure link to joanna.weiss@kipda.org.
    a. The second level review will be a formal review utilizing the agency's Executive Director and/or his designee, and two professional staff not involved in the program; or the KIPDA Aging and Disability Advisory Council Review Committee.
    b. The client will indicate on the Grievance and Complaint form how they want the second level review to be processed.
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I hereby certify that I have received and reviewed the following Grievance Policy Statement for the Waiver program participants.

I acknowledge these policies as a condition of the program and services at KIPDA. I understand I can contact KIPDA staff if I have any questions about these policies.

Name (print clearly):_____

Date: _____

Signature: _____

Area Agency on Aging and Independent Living
Area Development District
Metropolitan Planning Organization

KIPDA

KIPDA AAAIL/Waiver Program
Grievance & Complaint Form

Date_____

Client Name_____

Representative Name_____

Address_____

Phone Number_____

E-Mail Address_____

Nature of Complaint_____

_____

_____

_____

_____

_____

_____

Proposed
Resolution_____

_____

_____

Client/Representative Signature_____

Date_____

Send Form To: Quality Management Planner
KIPDA AAAIL/ADRC
11520 Commonwealth Dr, Louisville, KY 40299
Request encrypted email link to send at joanna.weiss@kipda.org

MAP-2000

If current waiver status and/or program is remaining the same, by signing off on this form you are agreeing to remain on HCB2 and authorizing the PDS Rep.

- **Client information to be filled out top of page 1**
- **Current Rep information to be filled out top of page 2**
- **PDS Representative to sign page 2 (where highlighted)**
- **Consumer/Guardian/Authorized Rep to sign page 2 (where highlighted)**

Map -2000
(Rev 06/15)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)/PARTICPANT DIRECTED SERVICES (PDS)

☐ **SCL**
☒ **MP**
☐ **HCB**
☐ **ABI**
☐ **ABI/LTC**

Member Name: _____ Medicaid Member ID #: _____

Case Manager/Support Broker: _____ _____
(Name) (Phone)

Provider Number: 33001405

☐ Addition of CDO/PDS Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option/Participant Directed Services for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my Plan of Care (POC)/Support Spending Plan (SSP) if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO/PDS.
- Bring whomever I want to all meetings pertaining to the CDO/PDS.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO/PDS Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a POC/SSP to meet my needs within the Consumer Directed Options (CDO)/Participant Directed Services (PDS) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO/PDS program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO/PDS program, and follow all tax and labor laws,
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO/PDS.

*For addition of CDO/PDS services

Date traditional case management ends and Support Broker begins ____/____/____
Date traditional services end and CDO/PDS services begin: ____/____/____

Kentucky UNBRIDLED SPIRIT

Map -2000
(Rev 06/15)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)/PARTICPANT DIRECTED SERVICES (PDS)

Member Name: _____ Medicaid Member ID # _____

☐ Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO)/(PDS) Program.

_____
(Address)

_____ **KY**_____ _____
(City) (Zip) (Phone)

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO/PDS representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO/PDS service, attach revised MAP 109-Plan of Care.

☐ Voluntary Termination of CDO/PDS Services Date: _____ Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

☐ Involuntary Termination of CDO/PDS Services
(To be completed by the Support Broker)

Reason for termination of CDO/PDS:
☐ Health and Safety Concerns
☐ Exceeding Individual Budget
☐ Inappropriate Utilization of Funds
☐ Other (Describe) _____

Traditional Provider Agency _____
Traditional Provider Number _____

_____ _____
Consumer/Guardian Signature Date

_____ _____
Representative Signature Date

_____ _____
Case Manager/Support Broker Signature Date

Participant Summary

For review – no signature required – please feel free to write on this form

Please write in and/or provide information to CM during POC meeting

Information to include in Emergency Plan

1. Emergency contact – Can be more than one – must be over 18.
2. Does this person have a legal guardian, POA, or conservator? If so, please obtain copies of paperwork.
3. Preferred hospital in case of medical emergency
4. Does this participant have natural supports in place if services/paid employees were unavailable? If, so who? Are they willing/able to provide paid and/or unpaid care in the event of an emergency?
5. Specific medical or behavioral challenges to note? What would you want someone to know about your loved one? i.e. – seizure disorder? Has and Epi Pen? Elopement Risk? Becomes triggered/aggressive in noisy crowds? ETC. This should not include universal concerns that would be true of most.

MPW PARTICIPANT SUMMARY

Completed by _____ **Date:** _____

Personal Information

Name:	DOB/Age:	SS#:
Address:	City/ST:	ZIP:
Phone:	Maid#:	

Emergency Contact Numbers

Guardian (Legal)	Name:	Home: N/A Cell:
Primary Caregiver	Name/Relationship:	Home: N/A Cell:
PDS Representative	Name/Relationship:	Home: N/A Cell:
Case Manager/Support Broker	Name: KIPDA 11520 Commonwealth Dr Louisville, KY 40299	Cell: Mon-Fri 8-5 & Emergencies 24hr: 1-866-519-1096
Primary Care Physician:	Name:	
Traditional Agencies: (List all)	Name:	
Transportation: Public Transportation	Name:	
Ambulance	911	
Fire Department	911	
State Police	911	
County Sheriff	911	
City Police	911	

EMERGENCY PLAN
Preferred hospital in the event of non-life threatening medical issue? Primary emergency contacts? Who would be willing to be provide unpaid back up care if natural support is unavailable?

Support broker/case manager, _____, should be contacted following any kind of critical or non-critical incident.

Medical

	NAME:	Protocol if ingested:
Medication Allergies:		

	NAME:	Protocol if ingested:
Food Allergies:		

Medical Providers

Primary Care	Name: see first page	Office:
Specialist:	Name:	Office:

Additional Information

Physical Limitations:
Behavioral Issues:
Living Situation:
Potential Risk:
Precautions and Actions:
Other:

HOSPITALIZATION AND MEDICAID FRAUD

When a Participant Directed Service (PDS) participant leaves the home and goes to the hospital, the participant is no longer eligible to receive paid services from the PDS employee. The Service Advisor needs to be notified of the hospitalization. Once the PDS participant has returned home, the PDS employee may begin billing for services as approved by the Plan of Care. Please contact the service advisor when the PDS participant returns home.

TIMESHEETS CANNOT BE COMPLETED FOR WORKING WITH A PARTICIPANT IN THE HOSPITAL.

MEDICAID CANNOT PAY OUT FOR TWO SERVICES AT ONE TIME.

FOR EXAMPLE: IF A PARTICIPANT IS RECEIVING THERAPY, THE PDS EMPLOYEE CANNOT BILL FOR SERVICES AT THE SAME TIME. SERVICES NEED TO STOP ONCE THE THERAPIST,DOCTOR,ETC ENTERS THE HOME AND THE EMPLOYEE MAY RETURN TO PROVIDING SERVICES ONCE THE THERAPIST,DOCTOR,ETC HAS LEFT THE HOME.

Participant Signature _____Date_____

Representative Signature_____ Date_____

Service Advisor Signature_____ Date_____

Area Agency on Aging and Independent Living
Area Development District
Metropolitan Planning Organization

KIPDA

KIPDA AAA WAIVER- 4/24

Medicaid Waiver
Telehealth Policy

Policy:
KIPDA AAA shall allow telehealth for Waiver case management services when requested by the participant and/or representative.

Procedure:
The waiver participant and or representative may choose to have case management services provided within the PDS and Traditional Waiver program by signing the KIPDA Telehealth Policy. This will allow case management to be conducted through a HIPAA compliant platform called Microsoft Teams. Telehealth Services will be scheduled by the Case Manager/Service Advisor and provided in a secure private location with the participant, representative and any others that the participant and or representative have requested to be in attendance. Telehealth services will follow the guidelines established in the current Home and Community Based Services Waiver regulation effective May 1, 2024.

I understand that the current 1915c Home and Community Based Waiver Services allow case management services to be provided through telehealth bi-monthly with a face-to-face home visit occurring bi-monthly.

I request telehealth services for _____my waiver case management.
(client name)

If I prefer to have a face-to-face home visit in place of telehealth I will request that when scheduling with my case manager.

_____ _____ _____
Participant/Representative Signature **Printed Name** **Date**

11520 Commonwealth Drive
Louisville, KY 40299
www.kipda.org

Phone: 502.266.6084
Fax: 502.266.5047
TDD: 800.648.6056

HELPING GROW 9 COUNTIES ACROSS KENTUCKIANA

Rep

FRAUD, WASTE AND ABUSE FACT SHEET
HOME AND COMMUNITY BASED (HCB) WAIVER

What is program fraud?

- Fraud is misrepresenting the truth or hiding information or facts.
- Fraud may occur if a Medicaid member, family member, representative, employee or agency gives false information or changes facts to benefit or get assistance from a state program.
- Fraud is defined by Kentucky law and can be found in KRS 205.8451. To read KRS 205.8451 you may visit https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=7851statute.aspx

What is program waste?

- Waste is the careless expenditure or use of program resources.
- Waste may occur if inefficient or ineffective practices results in cost to the program.

What is program abuse?

- Abuse is activities or practices that are not consistent with sound business or program guidelines and results in unnecessary cost to the state program.
- Abuse may occur if actions that are improper, inappropriate, and outside acceptable standards of the program are taken.

What is the difference between Fraud, Waste, and Abuse?

- Fraud requires the person to have an intent and the knowledge that their actions are wrong.
- Waste and Abuse may involve obtaining an improper payment but does not require the same intent and knowledge.

Approved by: DMS
Issued by: DAIL

Date Approved: 11/2021
Date Issued: 01/2022
DAIL Reference Number: 01-2022-A

KENTUCKY CABINET FOR
HEALTH AND FAMILY SERVICES

FRAUD, WASTE AND ABUSE FACT SHEET
HOME AND COMMUNITY BASED (HCB) WAIVER

- These differences are based upon intent and knowledge and depends on specific facts circumstances.

How is suspected Fraud, Waste and Abuse reported?

- Suspected Fraud, Waste and Abuse should be reported to the Office of Inspector General (OIG) by any person who knows or has reason to believe it is being committed.

- The OIG accepts tips and complaints from all sources on potential Fraud, Waste and Abuse

- The report may be made by:

Phone: (800) 372-2970
Email: chfs.fraud@ky.gov
Mail: Office of Inspector General
Division of Audits and Investigations
275 East Main Street, 5E-D
Frankfort, KY 40621

What information is needed to report suspected Fraud, Waste and Abuse?

- If known, the name and address of the person or agency suspected of committing the Fraud, Waste and Abuse and extent of the violation

- Any other information or details which may be helpful in investigation of the suspected Fraud, Waste and Abuse.

I confirm that I read, understand, and have no questions related to the material above. Further, I acknowledge it is my responsibility to report suspected fraud, waste, and abuse as outlined above.

Name: _____ **Signature:** _____

Waiver Role: _____ **Date:** _____

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KENTUCKY CABINET FOR
HEALTH AND FAMILY SERVICES

Rep

Abuse, Neglect and Exploitation

KIPDA has always had a suspected abuse, neglect, and exploitation policy to help protect vulnerable individuals. This policy has applied to all KIPDA employees who suspect abuse, neglect and exploitation of any KIPDA participant or vulnerable individual.

SUSPECTED ABUSE, NEGLECT AND EXPLOITATION OF VULNERABLE INDIVIDUALS

For Participants: Abuse of any type is not tolerated. Participants should report any suspected abuse (including concerns about themselves as victims) to their case manager, and to the Kentucky Abuse Reporting Hotline 1-877-597-2331 .

For KIPDA Staff:

Policy: KY State Law, KRS 209, requires all persons to report any suspected cases and/or situations of neglect or abuse of any vulnerable individuals including older adults.

Procedures:

· All KIPDA staff are to notify Adult Protective Services to report concerns of suspected neglect or abuse.

· All KIPDA staff are to indicate suspected neglect or abuse in a progress note indicating the nature of the situation and the date and time Adult Protective Services was contacted.

· Home care aides are to report concerns of suspected neglect or abuse to the KIPDA In-Home Services provider. Providers, either the aide or provider supervisor, shall notify Adult Protective Services. Providers are to contact the KIPDA case manager and note the concern/report in the participant database.

- KIPDA staff are to educate KIPDA participants on how they can self report their concerns about abuse, neglect and exploitation. They are encouraged to do so if they feel that they are in a potential situation. They should use the same numbers and websites listed here.

QUALITY ASSURANCE:

· The Director of Social Services and/or Quality Management Planner are to be made aware of the suspected neglect or abuse report.

· The Director of Social Services or designee, In-Home Services Coordinator, Waiver coordinator, Quality Management Planner, ICC/Case manager or Social Service Assistant will follow-up with Adult Protective Services case worker as to outcome of the possible investigation.

· Quality Management Planner is to review all documentation related to suspected neglect or abuse situations.

For Providers/Agencies/Contractors:

· All suspected cases of abuse and neglect should be reported to the Kentucky Abuse Hotline 1-877-597-2331 .

· All suspected cases of abuse and neglect should be reported to KIPDA management as well.

- Agencies should review other abuse, neglect and exploitation guidance in this section as well as in KIPDA's other policies, procedures and statements.
- Local authorities such as the police or 911 should also be contacted as appropriate.

KIPDA's Policy Statement on Suspected Abuse, Neglect and Exploitation of Participants, Participants, and Potential Participants

- KIPDA maintains a commitment to serving the most vulnerable people in the community. All too often, these are individuals who are at risk for being abused, neglected, or exploited. If any KIPDA staff member, volunteer, provider, or community partner suspects abuse, neglect, or exploitation of someone connected to a KIPDA service or program, they are advised to report their concern to their supervisor, to KIPDA, to the appropriate authorities, and to the Kentucky Abuse Hotline which can be reached either online or by phone:

- WebReferral (ky.gov)

- Kentucky Abuse Hotline 1-877-597-2331

- KIPDA staff and partners are advised to use the abuse hotline rather than the web referral for reports that appear to be of a more urgent nature. If there is an immediate danger, KIPDA's staff and partners are encouraged to call 911 as situationally appropriate. At times, KIPDA's staff and partners might opt to call the local police department's nonemergency number and request a health, safety, and welfare check. KIPDA's staff and partners are expected to use situational and professional judgement to determine the appropriate course of action. KIPDA's staff and partners are encouraged to consult with KIPDA management if the situation is unclear.

Date Signature

Printed name and role

employee

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HEALTH AND FAMILY SERVICES

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Date Signature

Printed name and role

KIPDA PDS Program EVV Guidelines

1. EVV must electronically verify six aspects of service delivery:
    a. the date,
    b. location,
    c. type of service,
    d. the individual providing the service,
    e. the individual receiving the service,
    f. start and end times of the service.
2. Manually entering timesheets does not capture the location of services provided, which is not in accordance with the Federally Mandated 21st Century Cures Act. This is considered an unverified visit. Manual entries **will not** be approved for Medicaid payment.
    a. **It is then you as the Employer (the participant/representatives) who is responsible for paying for any unverified visits**.
    b. Also,
        i. **1st offense**, a verbal warning will be issued to the participant/representative and employee. EVV training for proper usage will be reissued.
        ii. **2nd offense,** a Corrective Action Plan will be issued, and the employee will have 30 days to get within compliance.
        iii. **3rd offense**, an involuntary termination of PDS waiver services will be submitted to DAIL. Participant has the option of transferring to a traditional agency.
3. Always ensure that your employee submits time according to your prior approved plan of care. Employees are not allowed to exceed the prior approved amount of hours for services.
4. Always ensure that your employee submits tasks according to your approved plan of care. Employees are prohibited from selecting tasks that are not prior approved.
5. Ensure that your employees' time in and time out is correct before submission. Incorrect time will not be approved for payment. Corrections (when permitted) will first need to be made by the employee, then reviewed and approved by the you the Employer (participant/representative). Time entered at any time past the previous payroll period will not be processed for payment at a future date.
6. It is **strongly encouraged** for the participant/representative to review and approve employee's time daily. It is mandatory for you, the Employer (participant/representative), to review and approve employees' time at least on the bi-weekly schedule in order for the employees to be paid appropriately.
7. A Corrective Action Plan will be implemented if the same errors are consistently being made (Ex: forgetting to clock in and to clock out, clocking in and clocking out at an unauthorized address - also may be considered fraud and will be reported as such, selecting inappropriate tasks, selecting incorrect service codes. The participant will be at risk of termination of waiver services or will be transferred to a traditional agency, as described above.
8. Your employee will not be eligible to render services through the PDS Waiver Program if you are an inpatient of a hospital, nursing facility, rehab facility, mental institution, or hospice care. It is your responsibility to negotiate services outside of waiver approved services. Medicaid does not currently reimburse for services outside of approved care plans.
9. It is you, the Employer (participants/representative) responsibility to ensure that all employee eligibility paperwork is valid and kept up to date (Ex: **TB Skin Test, CPR/FA, DAIL Attendant Care Training, PDS Participant/Provider Contract, Vehicle Insurance, Driver's License**.) Both employee and participant/representative will receive weekly expiration notices in the Mains'l portal starting 6 weeks from the employee eligibility item expiration date. If any employee eligibility items lapse, payment will immediately be stopped until updated documentation is received. Your employee will not be eligible to render services through the PDS Waiver Program during the time of the lapse and there will not be payment issued for services during gap periods. All employee eligibility items are due in a timely manner.
10. Time submitted should be factual, complete, and accurate. Submitting time for services not rendered is considered Medicaid FRAUD. This would result in immediate termination of the Waiver program and legal action against you from the Department for Medicaid services. Suspected fraud will be reported to the Office of Inspector General immediately by KIPDA.
11. It is highly recommended that you as an employee have at least 2 weeks worth of payroll amounts to assure that employees are paid by you (outside of Medicaid) if lapses in your Medicaid, lapses in employee eligibility, and/or other instances occur that are not reimbursable by Medicaid.

❖ **Examples of Medicaid fraud include, but are not limited to:**

- Completing time or signing for someone else.
- Billing for unnecessary/unapproved services or items.
- Billing for services when the participant is in an alternative care setting.
- Billing for services while the participant is not present.
- Billing for services or items not rendered.
- Receiving "kickbacks" from your employee from Medicaid wages.
- Beneficiary fraud includes misrepresenting one's circumstances to obtain coverage, including PDS Services.

FRAUD is punishable by law and will result in legal action against you, the Employer.

Please remember participant confidentiality. Services are individualized; therefore, should not be discussed between other participants and/or employees. A breach of confidentiality dictates either loss of services and/or loss of employment.

_____ _____

Participant/Representative Signature Date

_____ _____

Employee Signature Date

REV 11.5.25

KIPDA Financial Management
MEDICAID WAIVER
VENDOR AND EMPLOYEE PAYMENT SCHEDULE

Pay Period		Representative Approval Due	Direct Deposit Date
12/14/2025	12/27/2025	December 28, 2025	January 9, 2026
12/28/2025	1/10/2026	January 11, 2026	January 23, 2026
1/11/2026	1/24/2026	January 25, 2026	February 6, 2026
1/25/2026	2/7/2026	February 8, 2026	February 20, 2026
2/8/2026	2/21/2026	February 22, 2026	March 6, 2026
2/22/2026	3/7/2026	March 8, 2026	March 20, 2026
3/8/2026	3/21/2026	March 22, 2026	April 3, 2026
3/22/2026	4/4/2026	April 5, 2026	April 17, 2026
4/5/2026	4/18/2026	April 19, 2026	May 1, 2026
4/19/2026	5/2/2026	May 3, 2026	May 15, 2026
5/3/2026	5/16/2026	May 17, 2026	May 29, 2026
5/17/2026	5/30/2026	May 31, 2026	June 12, 2026
5/31/2026	6/13/2026	June 14, 2026	June 26, 2026
6/14/2026	6/27/2026	June 28, 2026	July 10, 2026
6/28/2026	7/11/2026	July 12, 2026	July 24, 2026
7/12/2026	7/25/2026	July 26, 2026	August 7, 2026
7/26/2026	8/8/2026	August 9, 2026	August 21, 2026
8/9/2026	8/22/2026	August 23, 2026	September 4, 2026
8/23/2026	9/5/2026	September 6, 2026	September 18, 2026
9/6/2026	9/19/2026	September 20, 2026	October 2, 2026
9/20/2026	10/3/2026	October 4, 2026	October 16, 2026
10/4/2026	10/17/2026	October 18, 2026	October 30, 2026
10/18/2026	10/31/2026	November 1, 2026	November 13, 2026
11/1/2026	11/14/2026	November 15, 2026	November 27, 2026
11/15/2026	11/28/2026	November 29, 2026	December 11, 2026
11/29/2026	12/12/2026	December 13, 2026	December 25, 2026
12/13/2026	12/26/2026	December 27, 2026	January 8, 2027