

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

SELF-ADMINISTERED SERVICES AGREEMENT
Employer Service Agreement (ABI)

Date: _____, 20____.

1. PARTIES. This Self-Administered Services Agreement (referred to hereafter as "Agreement") is between the Utah Department of Human Services (referred to in this Agreement as "DHS"), Division of Services for People with Disabilities (referred to in this Agreement as "DIVISION"),

AND

Person receiving services (PERSON):

(Last, First, Middle I)

Street Address:

City:

State:

ZIP:

Phone Number:

Person's Identification Number (PID):

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Person's Representative (if applicable):

(Last, First, Middle I)

AND

ADMINISTRATOR. On _____, 20____, PERSON or Person's Representative was informed of the responsibilities for participation in this program and authorized the individual named below to serve as Administrator to assist PERSON in administering this Self-Administered Services Agreement:

Person/Person's Representative Signature:

Name of Administrator:

(Last, First, Middle I)

Administrator's Street Address:

City:

State:

ZIP:

Administrator's Phone Number:

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Person receiving services is referred to hereafter as "PERSON." Person, Person's Representative, and Person's Administrator are all legally bound Parties under this Agreement (regardless of whether Person, Person's Representative or Administrator are in fact the same individual), and are collectively referred to hereafter in this Agreement as "EMPLOYER."

2. PURPOSE. To define responsibilities of EMPLOYER and allocate funds to EMPLOYER for the purchase of specific services identified in this Agreement for or on behalf of

_____.
Insert PERSON'S name here

DIVISION has found PERSON to be eligible and has authorized PERSON to receive the specific services identified in this Agreement pursuant to PERSON'S Person Centered Support Plan (PCSP), dated _____, 20_____.

3. AGREEMENT PERIOD. This Agreement is effective on _____, 20_____, and terminates at the end of the plan year, _____, 20_____, unless terminated sooner in accordance with the terms and conditions of this Agreement.

4. SELF-ADMINISTERED SERVICES AMOUNT. Pursuant to the terms and conditions of this Agreement and with the full participation of EMPLOYER in the determination of assessed needs, DIVISION approves the following amount, \$_____ (*insert amount in General Funds*), as an authorized spending limit for the purchase of Self-Administered Services, that may be matched with federal funds for a total budget of \$_____ (*insert amount of total allocation for this program*), to be used toward the purchase of the specific services identified below for PERSON.

5. AVAILABLE SELF-ADMINISTERED SERVICES. (*Check all services that apply*). Authorized service codes, budget amounts, units and rates will be provided on PERSON'S PCSP. EMPLOYER must reference PERSON'S current PCSP for funding details. Note: rate includes employer taxes.

Chore Services (CH1)	Hourly _____	
Companion Services (CO1)	Hourly _____	
Financial Management Services (FMS)		Monthly _____
Homemaker Services (HS1)	Hourly _____	
Respite Care (RP1)	Hourly _____	
Respite Care/Room and Board (RP6)		
Supported Living (SL1)	Hourly _____	
Transportation (DTP)	Per Mile _____	

Note: Rates Include Employer-Taxes.

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6. AVAILABLE PROVIDER-BASED SERVICES. In addition to Self-Administered Services, the following services are available to all persons enrolled in DIVISION'S Medicaid ABI HCBS waiver and may be made available to the PERSON if the PERSON is determined to be in need of the particular service. Some of these additional services may be provided using a combination of Agency-based Provider Services, and Self-Administered Services:

- Behavioral Consultation Services (**BC1, BC2, BC3**)
- Chore Services (**CHA**)
- Companion Services (**COM**)
- Day Supports-Individual Services (**DSI**)
- Day Supports-Group Services (**DSG, DSP**)
- Environmental Adaptations (**EA1, EA2**)
- Homemaker Services (**HSQ**)
- Living Startup Costs (**STC**)
- Personal Budget Assistance (**PBA**)
- Personal Emergency Response Services (**PEI, PEP, PER**)
- Professional Medication Monitoring Services (**PM1, PM2**)
- Residential Habilitation Services (**RHS, HHS, ELS**)
- Respite (**RP2, RP4**)
- Support Coordination (**SCE**)
- Supported Employment Services (**SEC, SED, SEE, SEI**)
- Supported Living Services (**SLH, SLN**)
- Specialized Medical Equipment (**SM1, SM2, SME**)
- Transportation (**UTP, UTA, UTD, MTP**)

7. SPECIAL CONDITIONS. The DIVISION may change the Self-Administered Services amount covered by this Agreement at any time in order to reflect changes to the PERSON'S PCSP or changes in the PERSON'S assessed needs after giving EMPLOYER 30 days written notice of agency action and informing EMPLOYER of right to appeal.

8. DISBURSEMENT OF FUNDS. The funds disbursed under this Agreement will only be used to pay for actual services rendered. All funds disbursed through the Self-Administered Services program will be made through a Fiscal Agent under contract with the DIVISION. EMPLOYER is responsible to select a Fiscal Agent with the help of the Support Coordinator. The Fiscal Agent selected by EMPLOYER is _____.

Payments will not be issued or mailed to the EMPLOYER, but will be issued to the actual employee hired by the EMPLOYER. Supporting documentation, as required by UT Admin Code R539-5-4 must accompany all requests for payment. The DIVISION will not pay for services incurred in excess of the Self-Administered Services amount. Nor will the DIVISION pay for services not identified and approved in this Agreement or the PCSP. If EMPLOYER

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does not obtain services for PERSON equal to the Self-Administered Services amount during the period of this Agreement, neither EMPLOYER nor PERSON has any right to, or claim upon, the unused balance.

UNDER NO CIRCUMSTANCES WILL EMPLOYEES BE PAID USING PUBLIC FUNDS FOR WORK PERFORMED IF THE REQUIREMENTS OF UCA 62A-5-103.5 AND 62A-2-120, FOR OBTAINING A BACKGROUND CHECK AND RECEIVING APPROVAL FROM THE OFFICE OF LICENSING TO PROVIDE DIRECT CARE SERVICES TO CHILDREN OR VULNERABLE ADULTS, ARE NOT MET.

9. EMPLOYER'S RESPONSIBILITIES. In addition to the requirements otherwise set forth in this Agreement, the EMPLOYER shall be responsible to:

- A. Ensure employee compliance with DHS Provider Code of Conduct Policy 05-03, DIVISION Code of Conduct Policy 1.20, applicable DIVISION Administrative Rules and DIVISION Directives.
- B. Supply to the Support Coordinator and Fiscal Agent, all information as required by UT Admin Code R539-5, and as specified in the DSPD Self-Administered Services Support Book.
- C. Hire, fire, direct, and train employees who provide support to PERSON as outlined in PERSON'S PCSP, Behavior Support Plan, Support Strategies, and applicable DIVISION Administrative Rules.
- D. Ensure that each employee is qualified to provide the services for which that employee is hired to provide and that all billed services are provided.
- E. Ensure that prior to the provision of any services each employee complies with training requirements, has specialized training to meet the specific needs of PERSON, and is a certified Medicaid Provider, per Form 2-9C(ABI).
- F. Verify that all employees hired are sixteen (16) years of age or older. (Employee's Employment Agreement for individuals under eighteen (18) must be co-signed by their parent or guardian.) Parents, Guardians, and stepparents shall not be paid to provide support to their child, nor shall an individual be paid to provide support to his or her spouse, unless the exception in UT Admin Code Subsection R539-5-5(2) applies.
- G. Ensure that all employees hired by EMPLOYER understand and comply with the approved and prohibited behavior supports and procedures as identified in UT Admin Code R539-3 and R539-4, the Support Book, and other best practice sources recommended by the DIVISION. Behavior supports and procedures shall not violate

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R495-876, R512-202, R510-302, UT Code §§ 62A-3-301 through 62A-3-321, and 62A-4a-402 through 62A-4-412, prohibiting abuse.

- H. Participate in the Person-Centered Planning Process and in the development of support strategies. EMPLOYER must complete support strategies within 30 days after the completion of the PCSP. EMPLOYER shall also communicate with the DIVISION Support Coordinator on the effectiveness of the plan, identified strategies, and desired outcomes through Monthly Summaries submitted to the Support Coordinator by mail, fax, or email.
- I. Immediately notify the DIVISION Support Coordinator of any changes in circumstances or emergencies, which may require modification of the type or amount of services provided for in PERSON'S PCSP.
- J. Incident Reports:
- a. The EMPLOYER shall notify the Support Coordinator by phone, email, or fax of any incident that occurs **while PERSON is in the care of an employee**, within 24 hours of the occurrence.
 - b. Within five business days of the occurrence of an incident, EMPLOYER shall complete a Form 1-8 Incident Report and file it with the Support Coordinator.
 - c. The Following situations are incidents that require the filing of a report:
 - i. Actual and suspected incidents of abuse, neglect (including self-neglect), exploitation, or maltreatment per the DHS and DSPD Codes of Conduct and UT Code §§ 62A-3-301 through 62A-3-321 for adults, and which requires immediate notification to DHS Adult Protective Services intake in cases involving an adult, or DHS Child Protective Services intake in cases involving a child, or the nearest law enforcement agency;
 - ii. Drug or alcohol abuse;
 - iii. Medication overdoses or errors reasonably requiring medical intervention;
 - iv. Instances in which PERSON is considered "missing" for at least two hours or longer under unexplained, involuntary or suspicious circumstances and/or PERSON is believed to be in danger because of age, health, mental or physical disability, environment or weather, in the company of a potentially dangerous individual or some other factor placing the person in peril;
 - v. Evidence of seizure in PERSON with no existing seizure diagnosis;
 - vi. Significant property destruction (\$500.00 or more);
 - vii. Instances of physical injury reasonably requiring a medical intervention;
 - viii. Instances of law enforcement involvement or charges filed surrounding PERSON;

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- ix. PERSON has an aspiration or choking incident that results in the administration of the Heimlich maneuver (e.g. stomach thrusts), emergency medical intervention, and/or hospitalization;
 - x. All suicide attempts by PERSON (does not include threats of suicide);
 - xi. Human rights violations of or by PERSON such as the unauthorized use of restraints – physical restraints, mechanical restraints, chemical restraints (medications), seclusion rooms or infringement on personal privacy rights that would otherwise require a rights restriction plan;
 - xii. An event that compromises PERSON'S working or living environment such as damage to the home (e.g. roof collapse) that requires evacuation and puts PERSON at risk;
 - xiii. Death of PERSON;
 - xiv. Instances of any institutional admittance(s) as accommodation in a nursing home or a hospital; or
 - xv. Any other instances PERSON or EMPLOYER determines should be reported.
- d. After receiving an incident report, the Support Coordinator shall review the report and decide if further review is warranted. In all cases, the documentation surrounding the incident, and actions taken by the Support Coordinator in response to the incident will be submitted to DIVISION supervision for the purpose of administrative oversight.
- K. Comply with DIVISION staff requests for home visits to inspect program quality and conduct Agreement compliance reviews, and comply with the DIVISION requests to administer customer satisfaction surveys. (Note: EMPLOYER is also subject to review by the Department of Health and Division of Health Care Financing pursuant to program participation requirements.)
- L. Ensure a background check is completed and maintained on each employee.

10. TIMELY BILLING. EMPLOYER shall comply with all requirements of the Fiscal Agent and shall ensure accurate records and prompt payroll by: timely reviewing, signing and submitting employee timesheets; verifying the accuracy of hours worked; ensuring the appropriate expenditure of funds; and completing, maintaining and filing all necessary tax information required by the Internal Revenue Service. **(Note: Employees will not be paid prior to submission of required forms and verification. Failure to timely review, sign and submit employee timesheets will delay payment of employees.)**

11. REVIEW OF EMPLOYER'S BILLINGS. The DIVISION as well as the State Medicaid Agency (SMA) may review, at its sole discretion, all billings submitted by EMPLOYER to the Fiscal Agent for payment, and may deny payment if any charge is not properly supported. **If**

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DIVISION denies payment, EMPLOYER is still responsible to pay employee(s) for any services actually provided.

12. USE OF PUBLIC FUNDS. The funds covered by this Agreement are public funds appropriated to the DIVISION and approved by the DIVISION for the purchase of services for PERSON during the approved period and for the purposes stated in this Agreement. Parties acknowledge that public funds are subject to all applicable federal, state, and local laws and regulations pertaining to the use of public funds.

- A. Public funds are contingent on PERSON spend down. EMPLOYER will ensure that all required eligibility spend down is completed and reported to Utah Workforce Services (WFS) as required to maintain eligibility and understands that EMPLOYER will be held accountable for repayment of funds distributed and later denied due to ineligibility.

13. MISUSE OF FUNDS. The use of any of the funds provided under this Agreement for a purpose other than those expressly stated herein may subject the EMPLOYER to criminal prosecution, administrative sanctions, and liability for repayment of the misused funds.

14. PROVIDER AGENCY OPTION. EMPLOYER may use a portion of the allotted budget, based on assessed need, to obtain services through Provider Agencies in addition to continuing Self-Administered Services.

15. RECORD KEEPING RESPONSIBILITIES. EMPLOYER shall maintain copies of all required records and shall comply with all requirements of the Government Records Access and Management Act (GRAMA) found in UT Code Title 63G, Chapter 2.

16. LIABILITY OF EMPLOYER. Pursuant to this Agreement and DIVISION Administrative Rule, EMPLOYER has sole responsibility for hiring employees to provide services for or on behalf of PERSON.

In accordance with UT Code § 62A-5-103.5, DIVISION requires EMPLOYER to obtain a criminal background check from the Utah Bureau of Criminal Investigation (BCI) on all employees providing direct service care. As a condition of the Employment Agreement, the employee must fully disclose any convictions from a criminal offense other than a traffic violation and must promptly submit to a background criminal investigation.

In addition, DIVISION recommends that EMPLOYER require each employee to obtain a TB tine test results within one year prior to employment and no later than two weeks after employment through their local Public Safety and Health agency and to provide employees with extensive training on health and safety issues related to the PERSON.

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It is the responsibility of EMPLOYER to select, screen, and train employees to protect the health and safety of PERSON. **By choosing to participate in the Self-Administered Services program, EMPLOYER accepts all liability for any harm to PERSON or others, resulting from any action or inaction of the EMPLOYER in conducting screenings or tests on any employee, or in providing or not providing training in any specific area.**

17. INDEMNIFICATION. EMPLOYER agrees to indemnify DIVISION, DHS, and the State of Utah for the full amount of any judgment rendered against any one or more of them as a result of any action or inaction of EMPLOYER, or action or inaction of any employee hired by EMPLOYER pursuant to this Agreement, or any other harm to the PERSON that arises out of any action or inaction taken pursuant to this Agreement.

18. TERMINATION OF THIS AGREEMENT. This Agreement may be terminated by EMPLOYER at any time, or by DIVISION with 30 days written notice to EMPLOYER of its intent to terminate the Agreement. In addition, DIVISION may immediately terminate this Agreement at any time upon discovery of misuse of Self-Administered Services funds or any other action taken by EMPLOYER or employees of EMPLOYER pursuant to this Agreement that endangers the life or safety of PERSON.

19. JURISDICTION. The provisions of this Agreement shall be governed by and interpreted according to the laws of the State of Utah. The parties shall submit to the jurisdiction of the courts of the State of Utah for any dispute arising under this Agreement or relating to its breach.

20. SEPARABILITY CLAUSE. The declaration by any court or other binding adjudicative body that any provision of this Agreement is illegal or void shall not affect the legality or enforceability of any other provision of this Agreement unless such provisions are mutually dependent.

21. QUESTIONS ABOUT THIS AGREEMENT. EMPLOYER may direct inquiries about this Agreement to the assigned Support Coordinator.

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As EMPLOYER, my signature acknowledges that I have read, understand, and agree to the terms of this Agreement including all of the rights and responsibilities outlined in the Agreement. In addition, I have received a copy of, read, understand, and agree to abide by DIVISION'S Administrative Rules pertaining to this Self-Administered Services Agreement and use of a Fiscal Agent. I understand that the failure to abide by any of the

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terms of this Agreement may result in my loss of the privilege to receive additional Self-Administered Services funds under this Agreement or future Agreements.

As EMPLOYER, my signature also acknowledges that DIVISION does not endorse or recommend any employee to be hired or to provide services under this Agreement. In consideration of these promises and representations, and IN WITNESS WHEREOF, the parties have executed this Agreement as of the effective date set forth above.

AUTHORIZED ADMINISTRATOR

DIVISION REPRESENTATIVE

Type or print name

Type or print name

Signature

Signature

Date: _____

Date: _____

PERSON/PERSON'S REPRESENTATIVE (if different from Administrator)

Type or print name

Signature

Date: _____

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