

# EMPLOYMENT AGREEMENT SELF-ADMINISTERED SERVICES

## *Acquired Brain Injury Waiver*

Form Number: 2-9EA ABIW

Version Date: October 2021

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## 1. Parties

This Employment Agreement (referred to hereafter as “Agreement”) is between the PERSON or the PERSON’S representative (referred to hereafter as “EMPLOYER”), and the named EMPLOYEE.

### **EMPLOYER NAME:**

### **EMPLOYEE**

Name:

Social Security Number:

Phone Number:

Address: Include City, State, and Zip Code.

## 2. Purpose

EMPLOYEE has been retained by EMPLOYER to provide services to the person receiving services (referred to hereafter as “PERSON”).

### **PERSON NAME:**

Services provided to PERSON by EMPLOYEE are to be provided under the direction and supervision of the EMPLOYER. Identified below are the service(s) that the EMPLOYEE may be authorized and certified to provide at the direction of the EMPLOYER. Also listed below are the current rates of payment for authorized services.

Chore Services (CH1)	\$	per quarter hour
Companion Services (CO1)	\$	per quarter hour
Homemaker Services (HS1)	\$	per quarter hour

Respite Care (RP1)	\$	per quarter hour
Respite Care, Room and Board (RP6)	\$	per quarter hour
Supported Living (SL1)	\$	per quarter hour
Supported Living, Spouse (SL2)	\$	per quarter hour
Supported Living, Caregiver (SL3)	\$	per quarter hour
Transportation (DTP)	\$	per quarter hour

### 3. Employee Representations

- A. EMPLOYEE has completed all requirements in the Application for Certification Form 2-9C, and is certified to provide the limited services indicated in the Application for Certification Form 2-9C to EMPLOYER.
- B. EMPLOYEE SHALL BE EMPLOYED AT-WILL BY THE EMPLOYER. EMPLOYMENT AT-WILL MEANS THAT EMPLOYEE MAY QUIT AT ANY TIME FOR ANY OR NO REASON AND THAT EMPLOYER MAY DISCHARGE EMPLOYEE AT ANY TIME FOR ANY OR NO REASON. THIS AT-WILL STATUS MAY NOT BE ALTERED IN ANY WAY BY THE PARTIES.
- C. EMPLOYEE shall comply with all applicable Statutes and Administrative Rule as directed by the EMPLOYER and DIVISION of Services for People with Disabilities (DIVISION). EMPLOYEE shall specifically review and agree to comply with the Prohibited Procedures outlined in R539-3-10. Employee acknowledges and agrees that the DIVISION reserves the right to change its Administrative Rules at any time and for any reason, as deemed necessary in the DIVISION's sole discretion.
- D. EMPLOYEE shall adhere to the terms in of the Department of Human Services (Department) Code of Conduct, and the DIVISION Code of Conduct.
- E. EMPLOYEE shall adhere to the requirements and responsibilities outlined in PERSON'S support Strategies and Behavior Support Plan, if applicable.
- F. EMPLOYEE understands that pursuant to UT Admin Code R539-1, if an order by the Legislature or the Governor, or a federal or state law reduces the amount of funding to the DIVISION; or if the Executive Director of the Department reduces the funds available to the DIVISION this may change the terms of employment, including the rate of compensation to EMPLOYEE.
- G. Any additional hours of service that EMPLOYEE is asked to provide, outside this Agreement, are rendered under the EMPLOYER'S personal authority, accountability, and full liability.
- H. Any additional services that EMPLOYEE is asked to provide, outside the scope of this Agreement, are rendered under EMPLOYER'S personal authority, accountability, and full liability.
- I. EMPLOYEE has fully disclosed to EMPLOYER, any convictions from a criminal offense other than a traffic violation. EMPLOYER accepts full responsibility of receiving services from someone who has a prior

conviction.

- J. EMPLOYEE must be sixteen (16) years of age or older. (EMPLOYEES between the ages of sixteen (16) and eighteen (18) must have a parent or guardian co-sign this Agreement).
- K. EMPLOYEE must be eighteen (18) years of age or older, and be in possession of a current state issued Driver's License to transport or provide transportation services, or to provide services during overnight hours or during hours normally occupied by sleep.
- L. EMPLOYEE has a Valid Driver's License. Select One.      Yes                      No
- M. EMPLOYEE will sign and submit to EMPLOYER, accurate timesheets of all services rendered. Services are defined as "rendered" when EMPLOYEE'S signed timesheet is corroborated and signed by the EMPLOYER and submitted to the fiscal Agent. NO PAYMENT FOR SERVICES WILL BE MADE THAT DO NOT MEET THIS DEFINITION. Timesheets shall be submitted by the EMPLOYEE on a timely basis as directed by EMPLOYER. The timesheets shall include:
  - i. The type of service rendered;
  - ii. The date the service was rendered; and
  - iii. The number of services hours delivered (to the nearest ¼ hour when paid per ¼ hour)
- N. Funds used to pay EMPLOYEE for services rendered under this Agreement are public funds. Submitting false information on timesheets may subject EMPLOYEE to criminal action, administrative sanctions, and/or liability for repayment of any funds received pursuant to the submission of false information.
- O. Except as may be prohibited by law, EMPLOYEE must promptly notify and repay any overpayment to the Fiscal Agent selected by EMPLOYER, regardless of fault.
- P. EMPLOYER provides Worker's Compensation insurance. Select One.      Yes                      No
- Q. EMPLOYEE provides Medicaid reimbursable services. Select One.      Yes                      No
- R. When employed to provide care or services for which Medicaid reimbursement will be claimed, EMPLOYEE must:
  - i. Be aware of and comply with all appropriate and applicable Medicaid policies and procedures, and state and federal rules and regulations in effect when services are rendered;
  - ii. Provide care and services as authorized by the assigned Support Coordinator in accordance with all applicable Medicaid regulations and policies;
  - iii. Utilize a fiscal agent selected by EMPLOYER to submit claims for services in accordance with the Medicaid policy in effect at the time of service;
  - iv. Not bill EMPLOYER or otherwise attempt to collect payment for services from EMPLOYER, except as specifically permitted by Medicaid policy;

- v. Accept payment or claims adjudication from the Department of Health, as the State Medicaid Agency, as payment in full for services rendered;
- vi. Accept the status of independent contractor to the Department of Health, without authorization, express or implied, to bind the Department of Health or the State of Utah to any agreement, settlement, liability or understanding whatsoever;
- vii. Indemnify and hold harmless the Department of Health for any claims arising out of work performed by EMPLOYEE under authority of this agreement;
- viii. Not disclose information about PERSON, or concerning the care or services given to the PERSON, or other Medicaid recipients, except as specifically allowed by state and federal laws and regulations.

## 4. Background Screening and Clearance

Pursuant to Utah Law, UCA 62A-5-103.5 and 62A-2-120, EMPLOYEE is required to submit to a background check and be approved by the Office of Licensing before EMPLOYEE will be allowed to provide direct care to children or vulnerable adults. EMPLOYEE must maintain continuous background clearance by renewing EMPLOYEE'S background check with the Office of Licensing, within one year of the date of original clearance, and annually thereafter.

UNDER NO CIRCUMSTANCES WILL EMPLOYEE BE PAID USING PUBLIC FUNDS FOR WORK PERFORMED IF THE REQUIREMENTS OF UCA 62A-5-103.5 AND 62A-2-120, 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.

It is the responsibility of EMPLOYER and EMPLOYEE, NOT THE DIVISION to ensure that initial and annual background checks are completed. EMPLOYER WILL BE SOLELY AND PERSONALLY RESPONSIBLE FOR PAYING EMPLOYEE IF THE REQUIREMENTS OF UCA 62A-5-103.5 AND 62A-2-120 ARE NOT MET.

## 5. Acknowledgment and Signatures

I acknowledge that the Utah Department of Human Services, DIVISION of Services for People with Disabilities does not require the EMPLOYER to provide for any insurance coverage to compensate me if I am injured during the course of this employment. I also acknowledge that the DIVISION is not responsible for the actions of EMPLOYER and will claim governmental immunity for any harm or damages that I may incur during the course of my employment pursuant to this Agreement.

By my signature, I certify that I have read and agree to be bound by the terms of this Agreement. I acknowledge that my failure to abide by this Agreement may result in the loss of employment with EMPLOYER. I further acknowledge either party, with or without cause, may terminate this Agreement at any time.

EMPLOYEE Signature:

Date:

EMPLOYER Signature:

Date:

EMPLOYEE'S Parent or Guardian Signature required if EMPLOYEE is younger than 18 years old.

Parent/Guardian Signature:

Date: