Individual's Name: _____
OCHN CON ID: _____

Employment Agreement to Self-Direct Services
(For Direct Hire Staff)

This Agreement was made on _____, by and between _____ (the Individual Self-Directing services) or _____ (Legal Representative on behalf of Individual,_____) residing at _____ both separately and collectively hereinafter referred to as the Employer, and _____ (Direct Support Professional or "Employee"). The purpose of this agreement is to describe the general tasks and related duties of the Behavioral Health and Intellectual and Development Disability Supports and Services ("Supports and Services") that the employee will provide to the employer and the terms and conditions of employment as it relates to compensation using Medicaid/Public Funding.

Article I Employee Responsibilities

1. Provide support to the employer by performing duties outlined in this agreement, any attachments to it, and the Individual Plan of Service (IPOS).
2. Acknowledge that employment is dependent on the Employer's participation in a Self-Directed arrangement through Oakland Community Health Network (OCHN).
3. Submit documentation verifying that the minimum hiring requirements are satisfied as a precondition for employment and complete prior to working alone with the Individual and then update annually unless stated otherwise.
4. Agree to document services in a manner that fully discloses the extent of the services provided as required by Medicaid rules and as outlined in the Individual's IPOS. Documentation must correspond with timesheets, be complete, concise, accurate, and include the face-to-face time spent providing services. Documentation must be legible (i.e. easy to read), signed, and dated.
5. Maintain sufficient documentation of the services provided as required by my employer, Oakland Community Health Network, and as outlined in the Individual's Plan of Service.
6. All information in the record will be kept confidential and released only upon the written consent of the Employer. Acknowledge that all records are the property of the Employer and shall be returned to him/her at the time the employment relationship terminates.
7. Agree to assist the employer in filing Recipient Rights complaints upon request. Understand that I have a responsibility to report rights violations of which I am aware of or any potential abusive or neglectful situations I observe. I understand that I may be requested to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights. Complete Incident Reports when unusual incidents happen.
8. Agree to record real-time hours worked through the Electronic Visit Verification (EVV) system or to submit signed and dated payroll documentation to the employer to support payment of wages for

services rendered if no EVV is available. Paychecks shall be issued by the Financial Management Service Agency according to their contract with OCHN on behalf of the employer.

9. Authorize the Financial Management Services Agency to make payments outlined in the Employer's Budget. Payments may include Provider payments, employer tax payments, workers' compensation insurance, mileage, etc.

10. Understand and acknowledge that the Employer is the "sole" employer and that I am not an employee of Oakland Community Health Network (OCHN) which acts as the Pre-Paid Inpatient Health Plan (PIHP) and pays for services to the Financial Management Services agency, the Financial Management Service Agency, which is the financial administrator of funds used, or the Self-Determination Administration provider if any. All agencies will be held harmless for their role in administering Self- Directed services.

11. Understand that this employment is an at will relationship, which can be terminated by me or by the employer at any time. However, the employer cannot terminate my employment based on my race, religion, sex, disability, or other protected status under federal or Michigan law. In addition, I agree to give 14 days' written notice to my employer if I plan to terminate employment.

12. Understand that all timesheets and documentation to support the service must be submitted to the FMS no later than 30 days after the service was provided or Medicaid dollars cannot be used to pay for the service.

13. I agree to execute a Medicaid Provider Agreement (**Attachment A**) with OCHN and acknowledge that this agreement does not alter the fact that OCHN is only the PIHP. I understand that my employment is contingent on completing this agreement.

14. Acknowledge and sign **(Attachment B)**.

Article II Employer Responsibilities (Employer of Record)

1. Provide the Financial Management Service Agency with the necessary documentation to assure timely compensation for my employee, as identified by their payroll schedule. Timesheets and documentation must be submitted no later than 30 days after the service was provided, or Medicaid dollars cannot be used to pay for the service.

2. If the Financial Management Service (FMS) is utilizing an Electronic Visit Verification system (real time electronic timesheets), the employer will monitor the real time electronic signed time sheets and authorize payment for the delivery of services as specified in this agreement and not to exceed the authorizations as identified in the IPOS and individual budget. If the employee is required to submit timesheets to the FMS, the employer will verify support and services indicated on the timesheet prior to signing and submitting to FMS for payment.

3. Maintain copies of timesheets, employment agreements, training records, and service documentation that is complete, concise, accurate, and includes the face-to-face time spent providing services. Documentation must be recorded in a manner that discloses the full extent of the services provided, be legible, signed, and dated.

4. Acknowledge and agrees that the Financial Management Services Agency is acting only as a financial administrator and shall in no way be considered the employer, Oakland Community Health Network is acting only as the Pre-paid Inpatient Health Plan (PIHP) to pay the authorized services through the Financial Management Services Agency and is not the employer, and the provider organization acting as a Self-Determination Administrator, if any, is not the employer. The Employee agrees to hold the Financial Management Services Agency, the Self-Determination Administrator (if any), and OCHN harmless for their roles within this arrangement.

5. The Employer shall delegate duties to the Financial Management Services Agency to adhere to all federal and state employment obligations, including but not limited to: maintaining worker's compensation insurance, complying minimum wage standards and overtime regulations, withholding and payment of employment taxes, unemployment taxes, and all reasonable employer responsibilities.
6. Agree that OCHN or a delegated entity may suspend or terminate Medicaid/public funding for services provided by an employee if it is determined that the employee has failed to fulfill the terms outlined in the Employment Agreement, or if the employee has jeopardized the individual's health or safety or has misused the individual's funds.
7. Assure the employee maintains the required training. Training includes knowledge of Basic First Aid, Bloodborne Pathogens, Recipient Rights, and my employer's annual IPOS.
8. Assure the employee executes a **Medicaid Provider Agreement** with OCHN **(Attachment A)**.
9. Acknowledge and sign the Employer of Record training **(Attachment C).**

Article III Staff Compensation for Covered Services

The services must be covered. Services are covered when they are:

- Submitted for payment within 30 days of providing the service;
- Authorized in the Individual Plan of Service (IPOS) and provided face-to-face;
- Provided in a manner that meets Medicaid requirements;
- Provided in keeping with the Individual's IPOS and Individual Budget for the purpose of reasonably achieving the goals in the Individual's IPOS;
- Provided in keeping with this agreement (including attachments); and
- Documented appropriately.

The employee shall provide and will be compensated:
All wages must be between the state minimum and maximum wage allowable within the employer's Self-Determination Budget. Wages should not exceed OCHN's standardized rate, which is inclusive of all applicable taxes and insurance costs.

Select CWP or HSW if applicable:
☐ Children's Waiver Program (CWP) ☐ Habilitation Supports Waiver (HSW)

Living Arrangements:
☐ Employer lives alone.
☐ Employer shares staff with others in the home.
Number of employers/individuals sharing staff _____.

☐ **H2015 Comprehensive Community Support Services/XX402 Transportation for CLS**
☐ *Hourly rate of $_____ which is inclusive of mileage for MI only.
☐ *Hourly rate of $_____ with _____ miles per week. Mileage is paid at the current Federal rate.

☐ **T2027 Overnight Health and Safety Supports**
☐ *Hourly rate of $_____.

☐ **T1005 Respite**
☐ *Hourly rate of $_____.

☐ **H0045 (Daily) Respite Camp**
Daily rate is OCHN's standardized rate (if requesting a rate over the standardized rate, prior approval is needed).

☐ **Other** (All services will be paid at OCHN's standardized rate. If requesting a rate over the standardized rate, prior approval is needed).

CPT Code: _____ Type of Service: _____

CPT Code: _____ Type of Service: _____

CPT Code: _____ Type of Service: _____

Direct hire will ensure all health and safety needs are met as detailed in the Individuals Plan of Services. The employee is expected to perform services listed according to the goals/objective identified in the IPOS.

*****Pay rates and mileage cannot exceed the OCHN standardized rate for H2015, T2027, and T1005. These rates are authorized in units not hours (i.e. 4 units = 1 hour).

Article IV Term and Termination

This agreement will be in effect until such time as it is terminated or changed. This is an "at-will employment" relationship, which may be terminated by the Employer, at any time. However, the employer cannot terminate employment based on race, religion, sex, disability, or other protected status under federal or Michigan law. The agreement may be terminated immediately if there has been substantiated cause of abuse, neglect, or fraud.

Employee's Signature	**Printed Name**	**Date**

Relationship to the Employer _____

Employer's Signature	**Printed Name**	**Date**

Legal Representative's Signature	**Printed Name**	**Date**

Relationship to the Employer _____

Attachment A
Medicaid Provider (42 CFR 431.107) Agreement

This agreement is made on _____, between Oakland Community Health Network (OCHN), the Pre-Paid Inpatient Health Plan (PIHP), and _____ (Medicaid Provider). The purpose of the agreement is to define the roles and responsibilities of the above-mentioned parties and to ensure compliance with federal Medicaid requirements. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement. This agreement should not be finalized until the provider has met any additional requirements to provide Medicaid Services (i.e. background check, training). Should the provider fail to meet Medicaid requirements, OCHN may suspend or suspend or terminate this agreement.

OCHN Agrees to the following:

1. Upon receipt of this agreement, to certify the Medicaid Provider as available to provide Supports and Services to individuals Self-Directing their Supports and Services financed through Michigan's Medicaid Specialty Pre-Paid Mental Health Plan.

The Medicaid Provider agrees to the following:

1. To keep any records, it is necessary to disclose the extent of services the provider furnishes to the individual who receives services.
2. On request, to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed for furnishing services under the person-centered plan to OCHN, the State Medicaid Agency, the Secretary of the Department of Health and Human Services, or the State Medicaid Fraud Control Unit.
3. To comply with the disclosure requirements specified in 42 CFR 455, Subpart B, as applicable which state that I must disclose if I own 5% of another provider entity.
4. To comply with the advance directive requirements specified in 42 CFR 489, Subpart 1 and 42 CFR 417.436 (d), as applicable. This regulation requires that the provider acknowledge the doctrine of informed consent whereby all forms of medical treatment, including life-sustaining treatment may be declined by the consumer as specified.

Both parties acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. (The Social Security Act requires an agreement with each provider.) Further both parties recognize and reaffirm that OCHN is not the employer of the Medicaid provider of services.

This agreement sets forth the entire understanding between parties with respect to the subject matters, and supersedes all other agreements, either oral or in writing between parties, pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties. The parties agree to the terms and conditions of this agreement as specified on the foregoing page and so signify by affixing their signatures below.

_____	_____	_____
Medicaid Provider's Signature	Printed Name	Date
_____	_____	_____
OCHN Representative's Signature	Printed Name	Date

Internal Review Only

_____	_____
MCA Reviewer Name	Review Date

Attachment B

Employee Acknowledgement (Employer of Record Training)

1. Self-Directing services and the Individual Plan of Service were discussed with me, and I had the opportunity to ask questions.
2. Services authorized in the Individual Plan of Service (IPOS) have been reviewed with me.
3. The services I will provide were reviewed with me and I understand that I cannot bill OCHN for services above the services authorization outlined in my employer's IPOS.
4. I understand that all services I provide must be face-to-face while the person is in my presence. If services I provide are intermittent throughout the day, my electronic timesheets through Electronic Visit Verification shall accurately reflect such start and stop times.
5. I understand I cannot provide paid care if the person is admitted to the hospital.
6. I understand I must renew all trainings prior to the expiration date or I cannot be paid using Medicaid funds. Trainings include Basic First Aid, Bloodborne Pathogens, Recipient Rights, Emergency Preparedness, and my employer's annual IPOS. Additional trainings are at my employer's discretion.
7. If the Financial Management Service (FMS) utilizes an Electronic Visit Verification system (real time electronic timesheets), I have been provided with a username and password. Otherwise, I have received documentation on how to complete timesheet. I have also been provided with training materials and payroll submission guidelines.
8. I understand my electronic timesheets through Electronic Visit Verification are legal admission that the service was provided. Falsifying timesheets is Medicaid fraud and would need to be reported at the state and federal level and jeopardize the ability to work with this person and others receiving services.
9. I have the Financial Management Services Agency payroll schedule, and I understand that I have to turn in my signed and dated payroll documentation according to the due dates in order to be paid. Payroll documentation beyond 30 days will not be paid using Medicaid dollars.
10. I must provide documentation as required including any documents pertaining to employment.
11. I understand OCHN will only pay for hours that have been authorized in the IPOS. I understand any services I provide outside of the authorization is the responsibility of my employer.

My signature below confirms that the above information was discussed with me, and I understand and accept my role as an Employee for a person participating in a Self-Directed Arrangement.

Employee's Signature	Printed Name	Date

Attachment C

Employer Acknowledgement (Employer of Record Training)

1. Self-Directing services and the Individual Plan of Service were discussed with me, and I had the opportunity to ask questions.
2. My services authorized were reviewed with me and I understand that it is my responsibility to stay within the service authorization or as the employer; I will be responsible for paying for the difference.
3. I understand that all services I provide must be face-to-face while in my presence. If services are intermittent throughout the day, my electronic timesheets through Electronic Visit Verification shall accurately reflect such start and stop times.
4. I understand I cannot have paid staff to provide service if I am admitted to the hospital.
5. I understand my staff must renew all trainings prior to the expiration date or they cannot be paid using Medicaid dollars. Trainings include Basic First Aid, Bloodborne Pathogens, Recipient Rights, and my annual IPOS. Additional trainings are at my discretion.
6. Upon request, a username and password for the Electronic Visit Verification real-time electronic timesheets and training material may be provided. I have been provided with the submission guidelines. I understand that my signature and date on the payroll documentation verify the accuracy of the real time electronic timesheets regarding services provided.
7. I understand real time electronic timesheets are a legal admission that the service was provided. Falsifying timesheets is Medicaid fraud and would need to be reported at the state and federal level and jeopardize my ability to continue receiving services under the Self-Direction of services arrangement.
8. I have the Financial Management Services Agency payroll schedule, and I understand that I must turn in my staff's signed and dated payroll documentation according to the due dates for them to be paid. Payroll documentation beyond 30 days will not be paid.
9. I understand my Self-Directed budget and acknowledge that it is my responsibility to review the monthly budget reports that are sent to me every month. I understand I can contact my Financial Management Services Agency if I have any questions related to my budget or monthly budget reports.
10. I understand that no staff can start working with me or be paid for services prior to receiving formal approval from the Financial Management Service Agency to begin work.
11. I understand that my failure to comply with all responsibilities as the Employer of Record will jeopardize my ability to continue in this role.

My signature below confirms that the above information was discussed with me, and I understand and accept my responsibility as the Employer of Record participating in a Self-Direct Arrangement.

Employer's Signature (Individual or Legal Representative, if applicable)	Printed Name	Date