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

Kentucky Participant Directed Services
Employee/Provider Contract

I (*employee name*) _____, have agreed to work under the employment of

(*employer name)* _____.

Services under this contract will consist of the following:

SERVICE PROVIDED	**RATE PER HOUR**

Services Available Through Participant Directed Services:

(**SCL**) Community Access
(**SCL**) Community Guide
(**SCL**) Personal Assistance
(**ABI**) Companion Care
(**MPW**) Attendant Care
(**MPW**) Homemaking
(**ABI, ABI-LT, MPW,** and **SCL**) Respite
(**ABI, ABI-LT, MPW,** and **SCL**) Supported Employment
(**ABI, ABI-LT, MPW,** and **SCL**) Day Training
(**ABI-LT** and **MPW)** Community Living Supports (CLS)
(**ABI** and **MPW**) Personal Care

As an employee:

I agree to provide the above listed services as required by my employer at the rate stated above per hour.

I understand civil or criminal penalties could be pursued and potential termination from employment in PDS can occur if allegations of fraud against the Department for Medicaid Services are substantiated.

I understand that I shall not be approved as a Participant Directed Services (PDS) provider if results from my background check reveal that I have pled guilty to or been convicted of committing an offense as outlined in (SCL) 907 KAR 12:010, Section 3 (3), or (ABI) 907 KAR 3:090, Section 10, or (ABI-LT) 907 KAR 3:210, Section 10, or (MP) 907 KAR 1:835, Section 7.

I understand that I shall not be approved as a PDS provider if I am registered on the Kentucky Nurse Aide Abuse registry, or if I have been substantiated for abuse through the Central Registry Check.

I understand that I shall not be approved as a PDS provider for a participant under the ABI, ABI-LT, or MP waiver if I am registered on the Caregiver Misconduct Registry.

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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 Participant Directed Services provider. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor service advisor can be held liable for any injuries or losses I may incur while providing services.

I understand that I shall not be approved as a PDS provider for a participant under the SCL waiver if results from my drug screening reveal a positive drug test as outlined in 907 KAR 12:010.

I understand that if I do not complete all training that is required with the specified timelines, I will no longer be eligible as a PDS provider for the participant.

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 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.

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 and myself.

As an employer:

I understand that I may be responsible for costs associated for employment requirements, including employee training.

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/Provider Date Employer/Participant Date