LIFE PATTERNS
Financial Management Services for quality in-home supports

Please fill in blanks that are highlighted

EMPLOYMENT AGREEMENT

Between HCBS Participant and Direct Support Worker (DSW)

This Employment Agreement ("Agreement") is made and entered into on the date appearing below by and between the Employer (personally or by and through Employer's Responsible Party) and the Employee to provide services for the benefit of the designated HCBS Participant.

Employer/HCBS Participant: Individual Receiving Services
Employer's Responsible Party Directing Services (if applicable): Designated Representative, Parent/Guardian
Employee/Direct Support Worker (DSW): Employee, person providing the services

Employer and Employee (the "Parties") agree to the following terms and conditions:

1. Home and Community Based Services ("HCBS") Waiver Participant. The Employer is a participant in the Kansas HCBS What waiver (**IDD, PD, TBI, TA**) Medicaid Waiver Program.

2. Self-Direct Elective. The Employer has elected to self-direct his or her HCBS attendant care services.

3. Employment. The Employee agrees that he/she will at all times faithfully, industriously, and truthfully perform all of the duties required of his/her position. The Employer is solely responsible for scheduling Employee's work hours. In carrying out these duties and responsibilities, the Employee shall comply with all Employer directives, both written and oral, as are announced by the Employer from time to time. It is also understood and agreed to by the Employee that his assignment, duties and responsibilities and reporting arrangements may be changed by the Employer without causing termination of this agreement; provided however, such duties shall be subject to the contents and hourly limitations as contained in the Employer's HCBS Plan of Care.

4. Employment Orientation. Shortly after hiring and before the Employee can begin working, Employee shall contact the Employer's Financial Management Service ("FMS") provider, Life Patterns, Inc., to complete any and all payroll information, to receive various information and instruction regarding the use of the *Authenticare* system, and to provide information regarding required background checks. Use of the *Authenticare* system is mandatory. Employee shall abide by all directions, policies and procedures established by the FMS provider.

5. Compensation. As full compensation for services provided, Employee shall be paid at the rate to be established by the Employer and the HCBS waiver program. Such payments shall be subject to such normal statutory deductions (State and Federal) by the Employer's FMS Provider. The Employer determines that the Employee shall be paid within the pay range provided by Life Patterns, Inc. for DSWs at the rate of:

Pay Rates:
IDD PAS - $7.25 -$9.50
IDD Parent - $7.25 - $10.25
PD - $7.25 - $10.20
PD Parent - $7.25 -$11.00
TBI - $7.25 - $10.75
TA - $7.25 - $11.95
FE - $7.25 - $9.85

Enhanced Care Services
IDD Overnight Respite
$43.50 - $70.00
Please put amount/hour.

$_____ per hour for Personal Care Services (PCS)

$_____ per night for Enhanced Care Services (ECS) (if applicable)

$_____ for Overnight Respite Services (if applicable)

(NOTE: This amount is subject to yearly change based on rates of state/federal unemployment and worker's comp insurance.)

6. HCBS Plan of Care Provisions. Employee acknowledges that attendant care hours and services provided shall be as specified in the Employer's Plan of Care. Employee further agrees and understands that the Plan of Care is subject to change based on the Employer's health and welfare needs. Any services provided outside the Plan of Care will be not be paid by Life Patterns, Inc.

7. Compliance with Federal/State Laws and HCBS Program Waiver/Policies. The Employee further agrees to strictly comply with any applicable statutes, regulations or policies, state or federal, which relate or pertain to HCBS waiver services.

8. Payment for Services Rendered. Employee shall strictly comply with all rules, regulations, and/or policies (State or Federal), including those maintained by the *Authenticare* system, regarding logging of units/hours of services provided on a daily basis in order to receive payment for services rendered. Failure to provide accurate and truthful data regarding services rendered may result in termination and referral to State and/or Federal authorities for Medicaid Fraud, criminal prosecution or the like.

9. Agreement Term. This Agreement shall remain in effect pending the earlier occurrence of one of the following events: The denial of the Employer's Medicaid eligibility; the termination/closure of the Employer's HCBS case; the termination of the Employee as the Employer's self-directed worker (voluntary or involuntary termination); or the termination of the Employer's right to self-direct his or her care.

10. Termination. The Employee acknowledges that he/she is an Employee at will, and that Employer may terminate this Agreement, with or without cause, upon verbal or written notice to the Employee.

11. Benefits. The Employee shall be covered by Worker's Compensation Insurance and State and Federal Unemployment Insurance. No other benefits (health insurance, life insurance, sick pay) shall be paid under this Agreement.

12. Miscellaneous. The Parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. This Agreement may only be modified by a written agreement signed the parties hereto. The invalidity or unenforceability of any provisions of this Agreement shall not affect the other provisions hereof and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. This Agreement supersedes all prior negotiations and agreements between the parties relative to the transaction and services contemplated by this Agreement (written or oral), which contains the entire understanding of the parties. The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. In the event Judicial Intervention is necessary, the Parties agree that venue shall solely be in the District Court for Shawnee County, Kansas.

Please sign this Agreement and provide a fully executed copy to Life Patterns, Inc.

I have read and understand the terms and binding legal effect of this Agreement.

Individual who is receiving services; if parent/guardian with signature and SS#

Employer/HCBS Participant

Current Date

Date

Individual providing services

Employee/Direct Support Worker

Current Date

Date