



Direct Support Worker Data Sheet for Authenticare

DSW INFORMATION

Direct Support Worker Name:	
Social Security Number:	
Employer (<i>participant receiving services</i>):	
Indicate services worker provides:	<input type="checkbox"/> Personal Assistant Services <input type="checkbox"/> Sleep Cycle <input type="checkbox"/> Overnight Respite <input type="checkbox"/> Comprehensive Support
Is the worker Bilingual? (<i>yes/no</i>)	
Is the worker fluent in sign language? (<i>yes/no</i>)	
Language Accommodation Required? (<i>yes/no</i>)	

DISCLOSURE OF RELATIONSHIP TO HCBS WAIVER PARTICIPANT (CHECK ONE)

<input type="checkbox"/>	**Parent (natural or adoptive) AND Guardian of Participant**
<input type="checkbox"/>	**Parent (natural or adoptive) but NOT Guardian of Participant**
<input type="checkbox"/>	Spouse of Participant
<input type="checkbox"/>	Separated spouse of Participant
<input type="checkbox"/>	Ex-spouse of Participant
<input type="checkbox"/>	Grandparent AND Guardian of Participant
<input type="checkbox"/>	Grandparent but NOT Guardian of Participant
<input type="checkbox"/>	Sibling of Participant (must be 18+ years of age) Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Child of Participant
<input type="checkbox"/>	Other family member (i.e., stepparent, foster parent, aunt/uncle, first cousin, etc.): _____
<input type="checkbox"/>	No family relationship

DISCLOSURE OF PHYSICAL DWELLING (CHECK ONE)

<input type="checkbox"/>	I live in the same physical dwelling as the Participant
<input type="checkbox"/>	I do NOT live in the same physical dwelling as the Participant

In accordance with Medicaid policies, it is the Employer's (HCBS waiver participant or their guardian/representative) responsibility to notify the FMS provider (Life Patterns, Inc.) of any changes in the status of a Direct Support Worker. If any of the information provided on this form changes, it is the Employer's responsibility to notify Life Patterns within three business days.

Signature of Direct Support Worker

Date

****I understand that I am a parent employed by my child in domestic service. Therefore, based on State and Federal requirements, I understand Life Patterns Inc., the FMS provider for the above-named Participant/Employer, will not withhold FICA (Social Security & Medicare) from my paycheck. I further understand that I will not have Federal or State Unemployment coverage. ****