



Please fill in highlighted blanks

FINANCIAL MANAGEMENT SERVICE AGREEMENT BETWEEN PARTICIPANT/EMPLOYER AND LIFE PATTERNS, INC.

For this agreement the terms used shall mean:

PARTICIPANT/EMPLOYER: The person receiving services or their Guardian, Parent or other designated person directing the Medicaid HCBS Services is the **employer**.

DSW: The person hired by the Participant/Employer to provide Attendant Services authorized by the Person Centered Support Plan (PCSP) and Plan of Care.

This Financial Management Service (FMS) agreement is made and entered into on the date appearing below by and between the Participant/Employer Individual receiving services name (personally or by and through Employer's Responsible Party) and LIFE PATTERNS, INC., the FMS Provider.

The Participant/Employer and Life Patterns, Inc. agree to the following terms and conditions:

Home and Community Based Services ("HCBS") Waiver Participant. The Participant/Employer is a participant in the Kansas HCBS Waiver Program and has chosen to self-direct his or her HCBS attendant care services.

The Participant/Employer agrees to:

1. Comply with the Plan of Care/Integrated Service Plan or other documents authorizing services, and any Kansas statute, state or federal regulations or policy relating to services provided under the applicable HCBS Waiver Program for payment of services. This includes the Federal Department of Labor (DOL) ruling effective September 18, 2015 regarding domestic service employment which extends the Fair Labor Standards Act (FLSA) protections to most home care workers (minimum wage and overtime pay).
2. Assume all responsibility of employment of DSWs including but not limited to:
 - a. Interviewing potential DSW and deciding who to hire. The Participant/Employer will notify Life Patterns, Inc. in a timely manner of all new hires and submit appropriate paperwork.
 - b. Determining rate of pay: Employer will select rate of pay. Life Patterns, Inc. will establish the pay range based on current charges for State Unemployment experience rating and Workers' compensation Insurance within reimbursement rate set by KDADS. This pay range will vary yearly based upon these factors.
 - c. Providing sufficient training to DSW that is specific to meet the needs of the individual receiving services
 - d. Scheduling DSW work hours assuring the hours are within the Individual's specific Plan of Care. Hours worked that exceed the allotted hours on the POC are not billable to Medicaid and therefore will not be billed or paid by Life Patterns, Inc. It is the Participant/Employer's responsibility to pay any hours that are not paid by Life Patterns, Inc.
 - e. Assuring DSW work time hours are submitted to KS Authenticare. Any changes to times previously submitted or additions of "clock in" or "clock out" times must be sent in writing to Life Patterns, Inc. with all required information.
 - f. Supervising DSW activities.
 - g. Termination of DSW in the event the worker is not providing satisfactory service as determined by the Employer. The Participant/Employer will inform Life Patterns, Inc. in writing within 48 hours of termination (voluntary or involuntary). This will include documentation of reasons for termination.
 - h. Notify Life Patterns, Inc. of any work-related injury involving the DSW within 24 hours of the time of injury.
 - i. Understand that any penalties and overtime payment is your responsibility as the employer.
3. Comply with any instructions, rules or policies maintained by Life Patterns, Inc. with regard to billing and payment and consents to services including but not limited to: processing of time worked by the DSW, billing Medicaid on the Participant/Employer's behalf, distributing paychecks or making electronic deposits for time worked, and withholding, filing and paying appropriate taxes.
4. Notify Life Patterns, Inc. of an assigned Client Obligation and pay the assigned Client Obligation (if applicable) to Life Patterns, Inc. by the 10th of each month.

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 receiving services signature; or if parent/guardian - their signature

Current Date

Employer/HCBS Participant

Date

Employee/Direct Support Worker

Date