Memorandum of Understanding for the Administration and Co-Management of Community Habilitation Self/Family-Directed Option

this agreement is based on the understanding that				
	(Name of Individual)			
is and remains eligible for Community Habilitation (CH) services. By choosing the self-directed/family directed option, the individual/individual's family and the Provider Agency agree to co-manage the Community Habilitation self/family-directed (CH/SD) services as partners. In self-directed and family-				
			directed services, the Manager of Services is either the in	•
			clarification, please refer to Regulation 635-10.5 (ab)(11).	
the Employer of Record.	In both cases, the rigency will function as			
The Employer of Record.				
This plan is self-directed by				
(Name of Inc	dividual/Identified Adult)			
☐ This plan is family-directed by:				
on beha	of af			
(Name of Parent/Guardian/Identified Adult)	(Individual's Name)			
(Marile of Fall Shir) Saar alany 2001117100 Maariy	(znamodaro ramo)			
The Manager of Services agrees to the following respons	ibilities:			
 I will work cooperatively with the Employer of R 				
to provide these services. I understand tha	it I may recommend people that I know for			
consideration as possible staff, but that the Em	ployer of Record will make the final decision to			
hire someone based on the Agency's employmen	• •			
background check.	1 "			
Such gives and shoots.				
 I understand that staff I select who are hir 	ed by the Employer of Record, are assigned			
specifically to assist	with CH/SD.			
(Name of Individual)				
,				
 As the Manager of Services, I will oversee the 	ne staff's schedule and keep the Employer of			
Record informed of the schedule.				
 I will choose which habilitation activities in the (CH Plan that the staff will work on each day.			
	·			
 I am responsible for maintaining my Medica 	uid eligibility or the Medicaid eligibility for			
·				
(Name of Individual)				
Tundengtand that CLI/SD convices will be not	d for with nublic funds board on the someion			
 I understand that CH/SD services will be paid 	·			
documentation that staff must complete. I also	• •			
the provider's requirements for Medicaid docum	•			
inform the agency if I am aware of problems wit	h the service documentation			

• I will let the Employer of Record know about any special training I think the staff need. If

possible, I will also help to train the staff in these areas.

- If I am not happy with the staff's work, I will discuss my concerns with the Employer of Record and try to resolve the issues. I understand that any decision to terminate a staff's employment will be made by the Employer of Record in compliance with agency rules, but I may decide whether or not to work with a specific staff person.
- If I decide to discontinue this agreement, I will notify the Employer of Record at least 30 days in advance, as indicated in the "Discontinuation Process."

The Agency, as Employer of Record, agrees to the following responsibilities:

- We will consider people recommended by the Manager of Services as potential staff and assure
 that all staff will meet our requirements of employment, including background checks. We
 retain responsibility for making the final decision on whether or not a person meets the
 requirements to be hired as a staff. We will honor any decision on the part of the Manager to
 no longer work with an employee. We retain the right to make the final decision regarding
 termination or reassignment from employment.
- If we are not satisfied with a staff's performance, we will discuss our concerns with the Manager of Services and try to resolve the issues. Any decision to terminate a staff's employment will be made by the Employer of Record in compliance with Agency rules and procedures.
- We will provide and facilitate the training required by regulation and our agency's personnel
 procedures, as well as any additional training we find necessary or appropriate to meet the
 individual's needs. If the Manager of Services identifies additional training specific to the
 individual's needs, we will make every effort to assist with providing the training if requested
 to do so.
- We have responsibility for all payroll and personnel activities.
- We will review the service documentation that is completed by staff to ensure that the services are consistent with the individual's CH Plan. We will submit claims for payment based on this documentation.
- We will maintain a record of service hours and report the rate of usage to the Manager of Service at least quarterly.
- If we, as the Employer of Record, find it necessary to discontinue this MOU as indicated below in the "CH/SD Discontinuation Process", we will notify the individual/family at least 30 days in advance. We will also be responsible for notifying the individual's MSC and the DDSO CH Liaisons at least 30 days in advance; and we will continue to be party to this agreement until the 30 day period is completed or until alternative arrangements begin, whichever is sooner.

5 ,	the Individual/Individual's Family, as Managers of t nsibilities outlined in this MOU.	he CH Self-Directed/Family-Directed service, have
Signed:		
Manager of Services_		Date
	(Individual/Identified Adult)	
Employer of Record		Date
	(Agency Representative)	

COMMUNITY HABILITATION SELF/FAMILY DIRECTED DISCONTINUATION PROCESS

Either party may choose to discontinue this agreement as long as written notification of the intent to discontinue is provided to the other party in a manner that is consistent with this MOU. It is not necessary to complete this form if you are only changing or terminating a CH/SD staff person.

	ANTICIPATED LAST DATE OF THIS AGREEMENT://	
Please ide	ntify below:	
	As Manager of Services, I wish to discontinue this CH/Self/Family Directed agreement. This discontinuation does not negate my eligibility to continue participation in the Community Habilitation/Direct Support service offered by the Employer of Record.	
	As Employer of Record, we wish to discontinue this CH/Self/Family Directed agreement. We will continue to participate in this agreement for the management of 's CH services for 30 days or until an alternate arrangement (Name of Individual) is made, whichever is earlier.	
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•	ntinuation of the CH/SD agreement, the OPWDD may conduct an exit interview with the /or his or her identified adult using a statewide protocol.	
This document must be signed by the party who initiates the CH/SD discontinuation process as indicated above.		
<u>Signed:</u>		
Manager o	ServiceDate	
	(Individual or Parent/Guardian/Identified Adult)	
Employer o	f RecordDate	
	(Agency Representative)	