PAYROLL PROVIDER AGREEMENT

Between Payroll Provider and Direct Support Worker (DSW)

This Employment Agreement ("Agreement") is made and entered into on the date appearing below by and between the Payroll Provider and the Employee to provide services for the benefit of the designated HCBS Participant.

Employer/HCBS Participant: _____
Employee/Direct Support Worker (DSW): _____

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

1. 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.
2. 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.
    - Services cannot be provided to anyone who is an inpatient of a hospital, nursing facility, or ICF-IID.
    - No more than one worker can be paid for services at any given time of day.
    - Personal Care Services (PCS) cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services
    - Personal Care Services (PCS) cannot be provided for more than 12 hours max per day (unless written approval for exception by MCO is received by Life Patterns).
    - Personal Care Service workers are required to pass background checks consistent with KDADS background check policy prior to providing support and comply with all regulations related to abuse, neglect, and exploitation.
    - You must be with the individual you are providing support to and clocked in to be paid for the support.
    - You and the individual receiving services must be awake to be paid for PCS services.

    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.

3. Over-payment of Payroll Withholding / Reimbursement
    I, _____, understand that any services that are out of compliance with my employer's Plan of Care as noted above and have been paid to me by the Payroll Provider, and/or any amounts that have been paid to me that are in error or are unearned must be returned to Life Patterns. By my signature below I authorize Life Patterns to withhold from the next payroll and subsequent pay periods until the overpayment is reimbursed in full. Payroll deductions will be calculated based on the Federal minimum wage withholding guidelines. I understand, that at my choosing, I may submit the full amount of any overpayments within thirty (30) days of notification and forgo future payroll deductions. I understand that if my employment with my employer, the HCBS Participant, is terminated Life Patterns will initiate garnishment procedures.

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

_____ _____
Life Patterns, Inc **Date**

_____ _____
Employee/Direct Support Worker **Date**