Work Opportunities Reward Kansans (WORK)

Member Agreement Form

To be completed by the ILC and member

For more information about WORK services please go to https://www.kancare.ks.gov/consumers/working-healthy/working-healthy/work. You can find the WORK Program Manual on this website.

Participation: **(Choose and Sign one box)**

I **choose** to participate in the WORK Opportunities Reward Kansans (WORK) program. I understand my participation in WORK is completely voluntary.

Signature Date

I **do not** choose to participate in the Work Opportunities Reward Kansans (WORK) program. I understand my participation in WORK is completely voluntary.

Signature Date

Self Direction Choice: **(Choose and Sign one box)**

I **choose** to self-direct some or all of my WORK services. I understand I am the employer of record. I understand that this means that I will be responsible for hiring, training, scheduling, and firing of my staff for which I self-direct.

Signature Date

I **do not choose** to self-direct all my WORK services. I understand that I will not have the responsibility of hiring, training, scheduling and firing of my staff. I understand that my allocation payment will be sent directly to the Agency that is responsible for providing staff.

Signature Date

Representative:
A representative is a person who assists the WORK beneficiary in an unpaid capacity to make decisions about their services. A person may choose to have a representative or may make decisions on their own.

If you have a legal guardian/DPOA, this person is also a type of representative. Therefore, please list them below.

(Choose and Sign one box)

I, **choose** _____, to act as my
Representative Name
personal representative. This person will help me to make decisions regarding my WORK services in an unpaid capacity.

Representative Contact Information:		
Relation to Member:		
Representative Type:	Representative Payee	
Street Address:		
City:		
State:		
Zip Code:		
Phone:	Other	
Phone:	Other	
Email:		

This information must match the information provided on the WORK Assessment. If this is not on the WORK Assessment the ILC is responsible for notifying the MCO so the MCO can add this information to the WORK Assessment.

_____
Signature Date

I, **do not choose** to have a representative assist me to make decisions regarding my WORK services.

_____
Signature Date

Work Opportunities Reward Kansans (WORK)

As a member in WORK, I consent to the following:

Use of the WORK allocation funds and Individualized Budget:

I will receive a monthly allocation in a monthly amount determined by the WORK assessment to buy services and make other purchases related to my need for support for independence and employment. I understand that I will choose services and purchases that will best meet my needs and are cost effective. I understand that I will choose who provides my services.

If I choose to self-direct, I understand that I will be the employer of record for employees I hire.

I will develop an Individualized budget and I will decide what I will buy as long as I do not overspend my budget or make any purchases beyond what has been approved. I understand that if I overspend my budget and no longer have funds in my WORK account, I am responsible for the payment of employees and for purchases. I understand that I am legally required to pay employer-related taxes for the employees that I hire. My WORK allocation must be used to pay for employer-related taxes and Workers Compensation. I also understand that my individual budget must reflect the needs indicated in the assessment.

I will get help from my Independent Living Counselor to make sure that my budget is being used correctly.

I agree to follow WORK Program Manual guidelines.

Beneficiary Signature Date

Background Check:

All providers (includes self-directed personal care attendants) are required to obtain and pass State and national criminal history background checks on prospective employees. Background checks include the Kansas Bureau of Investigation, Kansas Adult Abuse, Neglect, Exploitation Central Registry and/or Child Abuse and Neglect Central Registry, Nurse Aid Registry, and Motor Vehicle screen. Individuals with prohibited offenses may not provide WORK services.

Members are also strongly encouraged to obtain references from previous employers, as well as personal references. Background checks do not come out of monthly allocations. The fiscal management organization will assist in obtaining background checks.

* **Central Registries, Excluded Lists, Terminated Providers**
  - Members may not use their *WORK* monthly allocation to pay personal assistants, or agencies, listed on the Health and Human Services Office of the Inspector General Office Exclusion List.
  - Members may not use their *WORK* monthly allocation to pay individuals or agencies on the Kansas Medicaid Program Integrity Terminated Provider List.

* **Prohibited Offenses** - Any provider of services found to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

(Self-direct portion of PAS services only, allocation funds are not available to provide background checks for agency –directed services)

Member Signature Date

Work Opportunities Reward Kansans (WORK)

Reporting Abuse, Neglect, Exploitation, and Fiduciary Abuse

Definitions

"Abuse" means any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a member, including:

- infliction of physical or mental injury;
- any sexual act with a member when the member does not consent or when the other person knows or should know that the member is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship;
- unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm a member;
- unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the punishment, for member or another member;
- a threat or menacing conduct directed toward a member that results or might reasonably be expected to result in fear or emotional or mental distress to a member;
- fiduciary abuse; or
- omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

"Neglect" means the failure or omission by one's self, caretaker or another person with a duty to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

"Exploitation" means misappropriation of member property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

"Fiduciary abuse" means a situation in which any person who is the caretaker of, or who stands in a position of trust to, a member, takes, secretes, or appropriates the member's money or property, to any use or purpose not in the due and lawful execution of such person's trust.

Reporting

I understand that my Independent Living Counselor and Case Manager are required by Kansas law to report concerns if they feel I am being abused, neglected, exploited, or subject I understand that I may report if I am being abused, neglected, exploited, or experiencing fiduciary abuse to the Department of Children and Families Adult Protective Services Kansas

Report Center at 1-800-922-5330

Member Signature Date

Member Benefits:

If you are receiving SSDI Cash Benefits: I understand that my WORK allocation will not be counted as income or resources for SSDI. I may decide to drop out of WORK at any time. However, if I have unspent WORK allocation funds they will be returned to the State of Kansas.

If you or someone in your household is receiving food stamps: My food stamp benefits will not change because of my decision to participate in WORK. I understand that WORK allocation funds will not be counted as income or assets for food stamp eligibility. I may decide to drop out of WORK at any time. However, if I have unspent WORK funds, they will be returned to the State of Kansas.

If you are receiving services from a program that is administered by DCF: I understand that my WORK allocation will not affect services I am receiving from programs provided by DCF. These programs include, the State Vocational Rehabilitation Services, State Supported Employment Services Programs, and Centers for Independent Living Programs.

If you have or will apply for a post-secondary education loan: I understand that my WORK allocation may be counted as income or assets for post-secondary loan program eligibility during my participation in this program. These programs include: the Federal Perkins Loan Program, The Federal Work-Study programs, the Federal Supplemental Educational Opportunity Grant Program, The FFEL Program, and the Federal Pell Grant Program. I understand that it is my responsibility to consult with my loan officer to see if my eligibility for post-secondary education loans will be affected by my participation in WORK.

_____ (Initial to show you have read and understood the above information)

Confidentiality:

I understand that all WORK information about me is confidential. I give my permission for WORK to release information about my participation in the program and how I use my allocation to the Centers for Medicaid and Medicare Services, the Social Security Administration, the Kansas Department of Health and Environment, and the Kansas Department for Children and Families.

This includes information on the forms I fill out and information collected from the Medicaid and Medicare programs about my use of medical services. WORK, Kansas Department of Health and Environment, the Social Security Administration, and the United States Department of Health and Human Services will hold my name in confidence to the full extent provided by state and federal law.

I understand that all information obtained in surveys and program records will be reported only for groups of people and will be used for research purposes only.

_____ (Initial to show you have read and understood the above information)

WORK to Waiver:
I understand that I can ask my Independent Living Counselor any questions I have about my rights as a member in WORK. If I decide WORK is not right for me, I may return to the Medicaid waiver Home and Community Based Services program or waiting list that I left. I will not be penalized in any way.

_____ (Initial to show you have read and understood the above information)

Member Rights

* Members have the right to information that will assist them in making an informed choice regarding whether they want to enroll in Working Healthy and WORK.
* Members have the right to timely enrollment in WORK.
* Members have the right to a person-centered planning process with all aspects of WORK, including the assessment, development of the Individualized Budget and Emergency Back-Up Plan, and completing the Member Agreement form.
* Members have the right to have the assistance of a representative, family, friends, or Independent Living Counselor with all aspects of WORK mentioned above.
* Members have the right to self-direct their services, choose an agency to direct services on their behalf, or to a combination of both self and agency-direction. KDHE does reserve the right, however, to require Members to have a family member, representative, or agency direct their services if there are concerns about the ability to self-direct their services.
* Members have the right to have criminal background checks conducted on their personal assistance providers.
* Members have the right to file a grievance with the MCO regarding WORK services, or appeal actions taken by the MCO to KDHE.
* Members have the right to report abuse, neglect, and exploitation to DCF.

Member Rights Signature

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Member Signature Date Signed

Member Responsibilities

* Members are responsible for complying with WORK program policies and procedures as laid out in the WORK Program Manual. Note: Members unwilling to follow these program policies and procedures will be required to leave the program.
* Members have the responsibility to provide eligibility staff, in a timely and complete manner, with all paperwork needed to complete annual eligibility and six-month desk reviews, without a disruption in services.
* Members are responsible for paying their Working Healthy premium monthly by the date specified on their statement.
* Members have the responsibility to obtain all necessary information to enable them to make an informed choice regarding whether they want WORK services.
* Members have the responsibility to be available for their initial assessment, and annual re-assessments, at the date and time agreed upon.
* Members have the responsibility to accurately report their need for services during the WORK assessment. NOTE: Falsifying the needs for services will result in removal from the program and be reported to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU).
* Members have the responsibility to ensure that the services and costs listed on their Individualized Budget reflect the needs identified during their WORK assessment.
* Members have the responsibility to complete an Emergency Back-Up Plan that ensures adequate coverage in the event that their employees do not come, and indicates that they have made provisions for their safety in the event of a natural or any other form of disaster.
* Members have the responsibility to sign all sections of the Member Agreement form, indicating the informed choices they have made, as well as their willingness to comply with the WORK program policies and procedures.
* Members are responsible to understand and accept the responsibilities and risks of directing their own care, as well as having knowledge of their rights, or designating a representative who understands their needs and is willing to accept the responsibilities and risks of directing their care; or choosing a state licensed Home Health agency, CDDO or Affiliate Agency willing to direct care on their behalf.
* Members have the responsibility to complete all of the paperwork required by the FMS provider in a thorough and timely manner to ensure that their PAs and providers are paid in a timely manner.
* Members have the responsibility to spend their monthly allocation on those services and/or goods that are consistent with independence and employment and within the parameters established by KDHE, and to spend no more than the amount allotted to them monthly.

* Members have the responsibility to verify time worked by approving time sheets. Falsification of time sheets, either by the Member or PA will result in removal from the program and will be reported to the MFCU.
* Members have the responsibility to submit timesheets in the timeframe identified by the FMS provider.
* Members are responsible to request the permission of their MCO Case Manager to spend carry-over funds.
* Members have the responsibility not to spend their allocation on anything prohibited by KDHE and/or MCO.
* Members have the responsibility to inform eligibility staff when they are no longer employed, and to contact their Benefits Specialist to set up a Temporary Unemployment Plan if they want to remain in WORK for a "grace" period of up to four months.
* Members have the responsibility to communicate any changes in status, needs, problems, etc. to the appropriate DCF, KDHE, or MCO staff.
* Members have the responsibility to inform their MCO Case Manager or Independent Living Counselor in a timely manner if they wish to return to an HCBS waiver or waiver waiting list.

Member Responsibilities Signature

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Member Signature Date Signed

Note: Inappropriate use of Medicaid funds is considered Medicaid fraud, will be reported to the Office of the Attorney General Medicaid Fraud Control Unit, and may result in prosecution.

Civil Rights

No person shall, on the grounds of race ,color, national origin, age, disability, religion, or sex, be excluded from participation in, be denied the benefits of or be subject to discrimination under any program or activity of the Department for Children and Families or Kansas Department of Health and Environment.

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Member Signature Date Signed

Signature Page:
I have read and understood this entire choice/consent form. I understand that I get to keep a copy of this choice/consent form.

Member Signature	Date Signed
Representative or Guardian Signature (If applicable)	Date Signed
ILC Signature	Date Signed