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Supporting Choice. Managing Costs.™

West Virginia Personal Options
Aged and Disabled Waiver Program
Enrollment Form

Name _____
Address _____
_____
_____ WV _____
City Zip Code
Phone _____
Email _____

Name of Representative (optional)
_____
Representative Phone
_____

Your PPL resource consultant is available to help you with the responsibilities of directing your own services. Your resource consultant is a support and will be there to help you understand and manage your program responsibilities. Your resource consultant will also help you monitor your health and safety through a monthly phone contact and a home visit every six-months. The information below covers important program responsibilities:

I understand I am responsible for:

- Maintaining a safe home environment for my employees and PPL staff;
- Scheduling and completing an annual re-evaluation of medical and financial eligibility for AD Waiver services by West Virginia Medical Institute (WVMI);
- Developing and revising my Participant Directed Service Plan;
- Developing and revising my monthly Spending Plan;
- Recruiting, screening, hiring, training, supervising, and dismissing my employees;
- Verifying qualifications of my employees and other service providers;
- Notifying my employees 24hrs in advance if services are not needed;
- Verifying on the timesheet and monthly documentation form hours worked and services provided by my employees and other providers;
- Refunding PPL in full in the event services are approved and paid and I did not maintain program eligibility, both financial and medical;
- Payment of goods and services that exceed my budget or are not in my approved spending plan;
- Refunding PPL in full in the event of over-payment for goods and services;
- Communicating any problems with services to my PPL resource consultant;

- Reporting any suspected fraud to my PPL resource consultant or West Virginia Medicaid Fraud Unit at 304-558-1858;
- Reporting any incidents of abuse, neglect or exploitation to my PPL resource consultant and/or the APS Hotline at 1-800-352-6513;
- Report any suspected illegal activity to my local police department or appropriate authority;
- Requesting payment for other goods and services as needed;
- Requesting a service level change or need for dual services as needed;
- Requesting to transfer to traditional agency services if desired.

I understand the following:

- I am a household employer of domestic employees under West Virginia Labor law.
- My employees must pass an initial criminal background check before providing services. The background check will need to be updated every three years.
- My employees must complete all initial training requirements before providing services and will also need to complete annual on-going training.
- My employee cannot be paid if they have not kept current all on-going employment requirements.
- Purchases of other goods and services may not exceed $1,000 per year.
- I cannot receive *Personal Options* services while I am in a hospital, rehabilitation facility or nursing home.
- If I am unable to receive AD Waiver services for 100 continuous days, my eligibility for ADW may be closed by the Bureau of Senior Services (BoSS).
- PPL will not pay for services if my financial or medical eligibility for AD Waiver services expires.
- I may be removed from *Personal Options* if I disregard these responsibilities.

I agree to:

- Comply with AD Waiver and *Personal Options* program requirements;
- Permit representatives of West Virginia Bureau for Medical Services (WVBMS), BoSS, and PPL;
- Be present for scheduled appointments.

I understand I have the right to:

- Considerate and respectful care from my providers;
- Appoint a representative to assist me if desired;
- File complaints and grievances with WVBMS, BoSS, and PPL;
- Transfer to traditional agency services if desired;
- Access the West Virginia Department of Health and Human Resources (DHHR) Fair Hearing process;
- Take part in decisions about my services;
- Confidentiality regarding my AD Waiver services;
- Access my files being maintained by PPL.

I agree to notify PPL immediately if:

- My medical status or direct care needs change;
- My phone number or address changes;
- My employees are no longer employed by me;

- I am admitted to a hospital, rehabilitation facility or nursing home;
- I am found medically or financially ineligible for AD Waiver services;
- My employee or representative forces me to continue *Personal Options* even though I am not getting needed assistance.

Peer Support Network (optional)

____ I am interested in participating in the Peer Support Network. I give PPL permission to share my name and contact information with other participants.

Voluntary Consent to Enroll

By signing below I certify that I understand and agree with all of the above responsibilities and choose to voluntarily enroll in *Personal Options.*

Signatures

_____ _____
Participant Date

_____ _____
Representative (Optional) Date

_____ _____
Witness (Required if signed with mark) Date