

Public Partnerships, LLC
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**West Virginia Personal Options
Traumatic Brian Waiver Program
Enrollment Form**

Name _____
Address _____

City _____ WV _____ Zip Code _____
Phone _____
Email _____

Name of Program Representative (if applicable): _____
Representative Phone: _____

Your Public Partnerships, LLC (PPL) resource consultant is available to help you with the responsibilities of directing your own services. Your resource consultant (RC) 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:

- Electing the participant-directed option;
- Working with my resource consultant to become oriented and enrolled in the Personal Options program, enrolling Qualified Support Workers (employees), developing a spending plan for the participant-directed budget, and creating an emergency back-up plan to ensure staffing;
- Revising my spending plan, as needed;
- Recruiting, screening, and hiring my employees;
- Verifying qualifications of my employees and other service providers;
- Providing required and member specific training to my employees;
- Determining my employees schedules and how and when my employees should perform the required tasks;
- Supervising my employee's daily activities;
- Notifying my employees 24hrs in advance if services are not needed;
- Evaluating my employee's performance;
- Verifying hours worked and services provided by my employees and other providers;
- Requesting payment for other goods and services as needed;
- Payment of goods and services that exceed my allocated amounts or are not in my approved spending plan;
- Refunding PPL in full in the event of over-payment for goods and services;
- Maintaining documentation in a secure location and ensuring employee confidentiality;

- Discharging my employees when necessary;
- 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 Department of Health and Human Services (DHHR) Adult Protective Services or Child Protective Services Hotline at 1-800-352-6513.
- Reporting any suspected illegal activity to my local police department or appropriate authority.
- Notifying my service coordinator of any changes in service needs and any hospitalizations;
- 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 and every three years thereafter.
- My employees must pass an initial screening of the Office of Inspector General exclusions list and every month thereafter.
- My employees must complete all initial training requirements before providing services and annually thereafter.
- My employee cannot be paid if they have not kept current with 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.
- PPL will not pay for services if either my financial and/or medical eligibility for TBI Waiver services expires.
- I am responsible for refunding PPL in full in the event services are approved and paid and I did not maintain program eligibility, either financial or medical.
- I am responsible for refunding PPL in full in the event of over-payment for goods and services.
- I may be removed from *Personal Options* if I disregard these responsibilities.

I understand I have the right to:

- Appoint a representative to assist me if desired;
- File complaints and grievances with PPL and/or APS/IRG Healthcare;
- Transfer my participant directed services back traditional agency services if desired.

I agree to:

- Comply with TBI Waiver and *Personal Options* program requirements;
- Permit representatives of BMS, APS and PPL to enter my home as scheduled;
- Be present for scheduled appointments.

I agree to notify PPL immediately if:

- 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 TBI Waiver services;
- My employee or representative forces me to continue *Personal Options* even though I am not getting needed assistance.

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*.

Participant Signature Date

Representative Signature (Optional) Date

Witness Name and Signature (Required if signed with mark) Date