public partnerships PPL
Your #1 choice for self-directed care™

EMPLOYMENT AGREEMENT

Attendant Name					
First:		**Last:**		**PPL ID:**	
Member Name					
First:		**Last:**		**PPL ID:**	
Employer Name (this must be completed)					
First:		**Last:**			

This agreement explains the responsibilities between the Member, Employer, and Attendant. Read this form in full so you understand what is required of you and others.

Terms and Conditions

1. I am an employee of the Employer. I am not an employee of Public Partnerships LLC (PPL) or Department of Health Care Policy and Financing (HCPF).
2. I am at least 18 years of age.
3. I agree to having State of Colorado perform a criminal background check and CO Board of Nursing check (BON).
4. I have not had a license or certification as a nurse aide revoked, suspended or denied. I am currently not under investigation by the BON.
5. I cannot begin working until:
   - I have successfully cleared all background checks
     - This includes Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
   - I have completed all paperwork
   - Member is approved for services
6. This agreement does not promise a certain number of hours of work.
7. I cannot work and be paid by the program for more hours than my Employer approves.
8. Information shared with me by my Member, Employer, and affiliated agencies must be kept private.
9. I will:
   - Be paid for services at a rate that is equal to or greater than the CO minimum wage or the federal minimum wage. Whichever is greater
   - Carry out duties and jobs assigned to me by my Member and Employer
   - Follow training policies and procedures as defined by the Department of Health Care Policy and Financing (HCPF)
   - Let all affiliated agencies know if I cannot contact my Member or Employer
   - Let PPL know if personal information changes
   - Follow all rules, regulations, and policies related to providing support services
   - Report all work-related injuries within 24 hours of the injury
   - Report possible:
     - Neglect
     - Abuse
     - Misuse of funds or property
10. My Employer will:
    - Tell me if I am hired
    - Tell me my start date, based on a “Good to Go” notice from PPL
    - Set the terms of my employment
    - Explain what I will be doing on the job
    - Explain my work schedule
    - Approve my service shifts

11. I can be terminated if:
    - I abuse, neglect, or misuse funds or property of the Member
    - I commit fraud or violate the terms of this Agreement
12. My service shift time must be correct and approved to be paid through the program.
13. I cannot submit service shifts or be paid through the program if:
    - My Member no longer has Medicaid
    - Services are not authorized
    - I work before PPL issues a “Good-to-Go” notice
    - I am no longer eligible under program rules to provide services
    - The Member is hospitalized
    - The Member is in a nursing home or similar facility
14. I am paid with federal and/or state funds. Submitting accurate information is required by law.
15. If I am paid for the work I did not do, I will have to pay it back. The Program through PPL will pursue all legal means to recover this amount.

If my employment stops for 6 months or longer, I may have to complete new paperwork.

Medicaid Fraud

Medicaid Fraud is a crime. It can lead to penalties and/or jail time. You must report any suspected fraud to PPL, the Case Manager, and/or the State.

Overtime

Any overtime worked without approval will not be paid by the Program. Spouses or relatives of the Member cannot work more than 40 hours a week, Sunday through Saturday.

Select your relationship to the Member: ☐ Spouse ☐ Relative ☐ Non-Relative

Change of Employer

If a new Employer replaces the previous Employer, they become the successor Employer. The Attendant must have continued to provide the same services to the same Member. The new Employer is required to keep completed forms. This includes the I-9.

Electronic Signatures

PPL supports electronic signing of forms if it is lawful and applies.

Electronic Visit Verification (EVV)

The Attendant must clock in and clock out for their shift using an approved EVV method.

Agree and Sign

The Attendant, Member, and Employer confirm:

- We have read all of this form
- The details we have provided are accurate and complete
- If employed, any false statement on this form may result in dismissal and further actions
- This form is not meant to be a contract of employment
- Employment depends upon verifying my right to work in the US
- It is the Employer’s responsibility to properly complete and execute the USCIS Form I-9
- We hold harmless, release, and forever discharge the CDASS Program and PPL from any claims and/or damages that might arise out of any acts or omissions by the Attendant, Member, Employer, or Representative

Attendant Signature: **Date:**

Member or Employer Signature: **Date:**