pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

Requalification
Direct Care Worker Information and Attestation Form

To complete your Requalification process, the Office of Long-Term Living (OLTL) program must collect all the information below. Please complete, sign, and date this five (5) page Information and Attestation Form and send it to OLTL through contractor Public Partnerships. You can fax to: 1-855-858-8158 or email to: padpw-oltl@pcgus.com.

<table>
<tr><th colspan="4">Participant/Employer Information</th></tr>
<tr><td colspan="2">Participant First Name:</td><td colspan="2">Participant Last Name:</td></tr>
<tr><td colspan="2">Employer First Name:</td><td colspan="2">Employer Last Name:</td></tr>
<tr><th colspan="4">Provider Information</th></tr>
<tr><td>Provider First Name:</td><td>Provider M.I.:</td><td colspan="2">Provider Last Name:</td></tr>
<tr><td>Have you ever used an Alias?
☐ Yes ☐ No</td><td colspan="3">Provider Maiden/Alias Name(s):</td></tr>
<tr><td>Unique Identification Number:</td><td>Date of Birth:</td><td>Social Security Number:</td><td>Gender:
☐ Female ☐ Male</td></tr>
<tr><td colspan="4">Relationship to Participant: ☐ Parent/Step-Parent ☐ Child ☐ Sibling ☐ Grandparent
☐ Grandchild ☐ Other Relative ☐ Non-Relative</td></tr>
<tr><th colspan="4">Physical Address</th></tr>
<tr><td colspan="2">Physical Address (do not use P.O. Box):</td><td colspan="2">Physical Address 2 (apt., bldg., unit, ste.):</td></tr>
<tr><td colspan="2">City:</td><td>State:</td><td>Zip Code:</td></tr>
<tr><td>County:</td><td colspan="2">Municipality (Borough or Township):</td><td>School District:</td></tr>
<tr><th colspan="4">Mailing Address (if different from Physical Address)</th></tr>
<tr><td colspan="2">Mailing Address:</td><td colspan="2">Mailing Address 2 (apt, bldg., unit, ste.):</td></tr>
<tr><td>City:</td><td>State:</td><td colspan="2">Zip Code:</td></tr>
</table>

Participant Name	Participant ID	DCW Name

Contact Information		
Preferred Method of Contact: ☐ Home Phone Number	☐ Mobile Phone Number	☐ Email Address
Home Phone Number:	Mobile Phone Number:	Email Address:
Office of Long-Term Living (OLTL), through Public Partnerships has permission to text me using the mobile phone number above (carrier charges may apply): ☐ Yes ☐ No		

Emergency Contact Information	
Emergency Contact Name:	Emergency Contact Phone Number:

Employee Qualification

Employer, please verify your worker has the mandatory qualifications to provide Participant-directed services by initialing all mandatory qualification requirements in Section 1 and initialing only those qualification requirements that apply in Section 2.

Qualification Validated	Section 1 – Mandatory Qualification Requirements
✓	At least 18 years of age
✓	Possess a valid Social Security number
✓	Possess basic math, reading, and writing skills
✓	Demonstrates the capability to perform health maintenance activities specified in the Participant's service plan. Or Completion of pre-training or in-service training necessary to carry out the Participant's service plan.
✓	Agrees to carry out the service responsibilities outlined in the Participant's service plan.
✓	Criminal History Background Check.
Qualification Validated (Please Initial All)	**Section 2 – Qualification Requirements (If Applicable)**
	Federal Bureau of Investigation (FBI) Clearance (when the applicant is not currently or has not been a resident of Pennsylvania for the two years prior to this application or when the Participant receiving service is under 18 years of age or there is a child under age 18 residing in the home of the Participant).
	Child Abuse Clearance per Child Protective Services Law (CPSL) [23 Pa. C.S. Chapter 63] (when the Participant receiving service is under 18 years of age or there is a child under age 18 residing in the home of the Participant).
	Valid driver's license (if transportation is provided as part of the service).
	Automobile insurance for all automobiles used as part of the service (if transportation is provided as part of the service).
	Current state motor vehicle registration (if transportation is provided as part of the service).

Participant Name	Participant ID	DCW Name

Mutual Responsibilities

The parties agree to follow the policies and procedures of the Office of Long-Term Living program (PA OLTL). The Provider and program Participant or Authorized Representative/Employer agree to hold harmless, release, and forever discharge PA OLTL and Public Partnerships from any claims and/or damages that might arise out of any action or omissions by the Provider, Participant or Authorized Representative/Employer.

Direct Care Worker (DCW) Agreement

I. Program Eligibility Questions:

- Does a child under the age of 18 reside in the home of the Participant? ☐ Yes ☐ No
- I have continuously lived in the state of PA for the past 2 years? ☐ Yes ☐ No
- Are you a spouse of, legal guardian for, representative payee or power of attorney to the Participant? ☐ Yes ☐ No
- I am at least 18 years of age? ☐ Yes ☐ No

II. Terms of Agreement

I recognize that my employment is contingent upon the Participant enrollment in the Participant Directed Services Program (PDS). If the Participant is no longer in the waiver or the PDS program, I may no longer be employed. To acknowledge the terms of my employment, I agree to the following:

1. I understand and consent to having State Police Criminal Background Checks, Child Abuse Clearances (when required), and Federal Criminal History Records (when required) completed on me and that my employment is contingent upon the results.
2. I understand that the results of my background checks will be made available to my prospective employer and other program administrators as necessary and/or required.
3. I understand that I cannot begin providing services in this program before I have successfully cleared the background checks and the employer has signed off as required by the program.
4. I agree to correctly complete all required paperwork.
5. I acknowledge that I will not start providing services until I am notified of my Good to Go status by my Employer.
6. I agree to provide the support as identified and authorized in the Individual Service Plan (ISP) in accordance with the outcome of health and safety requirements identified.
7. I agree to complete the required training and meet all necessary qualifications as required and identified in the ISP and the Office of Long-Term Living (OLTL) policies and procedures.
8. I understand that I may not submit time records for any time period for which a Participant is admitted to a hospital, nursing home, rehabilitation facility or for any period for which the Participant is not eligible for waiver services.
9. I agree to maintain the necessary documentation and records as required by the PDS program and by my employer. All records I may have or assist in maintaining will be kept confidential.

Participant Name	Participant ID	DCW Name

10. I agree to report incidents to my Participant's service coordinator, including suspected abuse, neglect, exploitation or any event involving error in service/support implementation, critical events involving personal injury, illness, medical emergency or any event determined to be atypical as required by the Office of Long-Term Living (OLTL), or my employer.
11. I agree to take part in any meetings if requested by and/or regarding the Participant/Employer.
12. I agree to abide by all applicable rules, regulation, and policies pertaining to providing support services through the PDS program.
13. I hereby acknowledge that I have received, read, and understand all the following information:
    a. OLTL program policies and procedures regarding PDS
    b. The Individual Service Plan (ISP)
14. I agree to review any/all programmatic updates made available to me by my employer.
15. I understand that the Office of Long-Term Living (OLTL), though its contractor Public Partnerships will verify that I do not appear on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). In the event I appear on this list, I will not be permitted to work or be paid in this program.
16. I understand that in consideration of the above stated agreement, I shall be compensated through this program for only those services approved by my employer and authorized in the ISP.
17. I understand and acknowledge that Public Partnerships is not my employer.
18. I understand that the Participant or their appointed representative is my employer. My employer is not Public Partnerships, OLTL, or any other entity involved with the PDS program.
19. I understand that my paychecks will be processed by the OLTL, through its contractor Public Partnerships. Public Partnerships is contracted by Office of Long-Term Living (OLTL) to serve as the Financial Management Service (FMS) Organization. I understand that Public Partnerships is not authorized to pay for any service not approved and authorized in the ISP or any request that exceeds the Participant's budget and funds for the PDS program as stated in the ISP; for such services, I understand that my employer would be responsible for any payment.
20. I understand and agree that any payments made for services that I have not performed will be subject to repayment by withholdings from future paychecks. This includes overpayments made because of error or omission. The withholding process will be governed by applicable law. The OLTL, though its contractor Public Partnerships will pursue all legal means to recover the amount of overpayment.
21. I understand and acknowledge that any false claims or untruthful submission of services provided, statements, or documents, or concealment of material facts to obtain improper payment is reportable as Medicaid Fraud and subject to investigation. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.
22. In accordance with §52.28, I agree to self-disclose a conflict of interest to the Office of Long Term Living (OLTL).
23. I understand and acknowledge that information I provide may be shared with business partners who work with the Office of Long-Term Living (OLTL) and the OLTL's contractor, Public Partnerships, to provide services to my Employer.

Participant Name	Participant ID	DCW Name

Attestation

By signing below, I attest that I have read this agreement in its entirety. I understand I must sign and return this form as a condition of participation in this program, and that I cannot begin working until this form is completed and returned to the Office of Long-Term Living (OLTL), though its contractor Public Partnerships. I further attest by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions of this agreement may result in termination of this agreement and payment for employment to any Medicaid Recipient of this program.

I understand I must sign and return this form as a condition of participation in this program. I further attest by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions may result in termination of this agreement.

I understand that I must attend a Direct Care Worker Pre-Service Orientation session (if not done previously and enrolling after November 30, 2018) before I can become Good to Go and start providing services.

I authorize the Employer and the Office of Long-Term Living (OLTL), though its contractor Public Partnerships to proceed with all registry and criminal record checks required by state and federal law. This information cannot be released for any other purpose without my written permission.

Employer of Record Name

Employer Signature　　　　Date

Provider Name

Provider Signature　　　　Date