PCG Public Partnerships
Supporting Choice. Managing Costs.™

Simply healthcare

Direct Service Worker (DSW)
Employment Information & Attestation Form

In order to process your service payments Public Partnerships, LLC (PPL) needs to collect all of the information below. Please complete, sign and date this eight (8) page ***Employment Information & Attestation Form*** in its entirety and submit it to PPL.

Participant First Name:	**Participant Last Name:**

DSW First Name:	**DSW M.I.**	**DSW Last Name:**
DSW Maiden/Alias Name(s)	**DSW's Relationship to Participant:**	

Contact Information

Physical Address *(leave blank if same as mailing address)*	
Physical Address 2 (apt, number etc…) *(leave blank if same as mailing address)*	
City *(leave blank if same as mailing address)*	**State and Zip Code** *(leave blank if same as mailing address)*
County *(leave blank if same as mailing address)*	
Mailing Address	
Mailing Address 2 (apt, number etc…)	
City	**State and Zip Code**
County	

Primary Phone No./Extension	**Cell Phone No.**
Alternate Phone No.	**Fax No.**
Email Address	

Emergency Contact Name:	
Emergency Contact Phone Number:	**Relationship:**

Tax Identification No. / Social Security Number ___-___-___ ___-___ ___-___-___-___	**Date of Birth** ___ ___/___ ___/___ ___ ___ ___
Gender **____ Male ____ Female**	**Marital Status** **____ Single ____ Married**

Criminal Background Check Application Information

Place of Birth			
City	**State**	**County (if known)**	**Country**

Race *(please check one)* _____American Indian and/or Alaskan _____ Asian or Pacific Islander _____Black _____ White (includes Mexicans and Latinos) ____Unknown

Eye Color *(please check one)* _____Black _____Blue _____Brown _____Green _____Gray _____Hazel _____Maroon _____Multi Colored _____Pink _____Unknown

Hair Color *(please check one)* _____Bald _____Black _____Blonde ____ Blue _____Brown _____Green _____Gray _____Orange _____Purple _____Pink _____Red _____Sandy ____White _____Unknown

Height _____ Feet _____ Inches	**Weight (Pounds) _____**

Direct Service Worker (DSW) Pay Rate

(*This information is necessary in order to process your timesheets***)**

Service (Procedure Code)	Rate per Hour
Adult Companion Care	$
Attendant Care	$
Homemaker	$
Personal Care Services	$
Intermittent and Skilled Nursing	$

Account Detail Information

(*This information is necessary to process your payment via pay card or direct deposit. Only complete one*)

For Direct Deposit Setup:
Please include a copy of a blank check or a letter from your bank confirming the bank routing and bank account number.

Financial Institution Name (*only for Direct Deposit*)

Bank Account Number	**Routing Number**
___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ ___ ___ ___ ___ ___ ___ ___

Account Type (*please check one-only for Direct Deposit*)

____ Checking ____ Savings ____ Debit Card

For Debit Card Setup :
Please indicate below that you would like to be setup for the Debit Card.

____ YES, Please set me up to receive payments via Debit Card.

____ NO, I will receive payment via Direct Deposit into my Checking or Savings Account.

Relationship Status

(*This information is necessary so that we can determine if you are eligible for tax withholding exemptions***)**

1. Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1 or Q-1 visa admitted to the US for the purpose of providing domestic services?

_____ Yes, That description fits my status ____No, that description does not fit my status

2. Are you the child of the employer (includes adopted children)?

____ Yes, my employer is my parent (mother or father) _____No, my employer is not my parent

3. Are you the spouse of the employer?

____ Yes, my employer is my spouse (husband or wife) ____ No, my employer is not my spouse

4. Are you the parent of the employer (includes adopted children)?

___ Yes, my employer is my child (son or daughter) ____ No, my employer is not my child

5. *If you answered "Yes" to Question 4, check any of the following that apply. If you answered "No", proceed to Question 6.*

___ Yes, I also provide care for my grandchild or step-grandchild in my child's home.

___ Yes, my grandchild or step-grandchild is under 18, or has a physical or mental condition that requires personal care of an adult for at least four continuous weeks during the calendar quarter in which services are performed.

___ Yes, my child (son or daughter) is widowed and divorced and not remarried, or living with a spouse who has a mental or physical condition which prohibits the spouse from caring for my grandchild for at least four continuous weeks during the calendar quarter in which services are performed.

6. Are you under the age of 18 or do you turn 18 this calendar year?

___ Yes, I am under 18 or turning 18 this calendar year. ____ No, I am over 18.

If you answered "Yes" to Question 6, answer the following question. If you answered, "No" skip the questions below.

Is this job of performing household services (respite or nursing) your principal occupation? **Note:** Do not answer "Yes" if you are a student.

Yes ___ No

Difficulty of Care Exclusion

(Certain payments received by an employee for providing Medicaid services in the Employer's home are considered Difficulty of Care payments excludable from federal income tax. To determine if you are eligible for the income exclusion, complete the following steps. If you are eligible, PPL will not report the payments as income and will not withhold federal income taxes.)

STEP 1: Review information regarding the Difficulty of Care Federal Income Tax Exclusion. Information is available on PPL's website at: http://www.publicpartnerships.com.

STEP 2: Check all that apply:

- ☐ *I provide services to the Employer in my home.*
- ☐ *I do not have a separate home where I reside.*
- ☐ *This is the home where I reside and regularly perform the routines of private life, including shared meals and holidays with family***.**

STEP 3: If all of the above apply, you are eligible for the Difficulty of Care Federal Income Tax Exclusion.

General Service descriptions are listed below:

PDO Service	Description
Adult Companion Care S5135	Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.
Attendant Care S5125	Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity. Unskilled attendant care must have supervision provided by a registered nurse, licensed to practice in the state.
Homemaker Services S5130	General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services, and pest control may be included in this service.
Intermittent and Skilled Nursing T1002 (RN) T1003 (LPN)	The scope and nature of these services do not differ from skilled nursing furnished under the State Plan. This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services coverage under this waiver. Services listed in the plan of care that are within the scope of Florida's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled nursing services must be listed in the enrollee's plan of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable.
Personal Care Services T1019	A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

Direct Service Worker Qualifications

As the Direct Service Worker, I understand that if I provide services in the Participant Directed Options program I must comply with the following qualification requirements.

1. Direct Service Workers must be at least 18 years old.
2. Certified in CPR and First Aid (*if required by your participant's case manager*).
3. Pass a Level 2 background screening pursuant to chapter 435 and section 408.809, F.S.

For those individuals hired to perform Nursing Services in ***Intermittent and Skilled Nursing*** you must also submit proof of either:

1. Registered Nursing License; in accordance with Chapter 464, F.S.
2. Licensed Practical Nursing License; in accordance with Chapter 464, F.S.

Direct Service Worker Responsibilities

As the Direct Service Worker I understand my responsibilities are as follows:

1. Will treat the participant with dignity and respect. This includes respecting personal beliefs, culture, religion, and privacy as well as respect for the participant's personal property.
2. Will keep the participant's personal information about the participant and his or her family confidential.
3. Will communicate effectively with the participant. If the participant has a preferred communication method, this should be respected and utilized.
4. Will document hours of service provided on the appropriate PPL timesheet.
5. Will provide safe care. Universal precautions must always be utilized.
6. Will immediately report an emergency situation by calling 911.
7. Will report any suspected abuse, neglect, or exploitation of a participant to the proper authorities. Some occupations, such as nurses, are required in Sections 39.201 and 415.1034, Florida Statutes to be mandatory reporters. Suspected instances of abuse, neglect, or exploitation should be reported to the Florida Abuse Hotline, 800-96-ABUSE (22873).
8. Will communicate any change in the participant's condition, including an admission to a health facility if the participant is unable to do so.

9. Will provide adequate notice if you will be unable to provide the scheduled service to the participant, as soon as possible. This includes notifying the participant in advance if you must be absent for a portion of a scheduled service or will be arriving late.

10. Will provide a two week notice to the participant if you will be voluntarily terminating employment.

Employer's Responsibilities

As the Employer or Representative (as appropriate), I understand my responsibilities are as follows:

1. Employers/Representatives will review and verify the Form I-9 information using acceptable Employee documents. Employers will ensure that the Direct Service Worker forwards a copy of the completed I-9 to PPL and will maintain the original with their program records.

2. Understand and acknowledge that Public Partnerships, LLC (PPL) serves as my Fiscal/Employer Agent (F/EA) and that I, the participant, am the legal employer in the Participant Direction Option (PDO) program.

3. Will treat the direct service worker with dignity and respect. This includes respect for the direct service worker's personal beliefs, culture, religion, and privacy.

4. Training the direct service worker in the manner in which services will be performed and/or requesting assistance from the case manager, if necessary.

5. Scheduling the direct service worker's work hours.

6. Ensuring that all required paperwork, including timesheets, is accurately completed and submitted to PPL as directed. Failure of the participant to accurately represent actual hours of service received is subject to a Medicaid fraud investigation and ends participation in the PDO.

Attestation

By signing below, I and my Employer attest that we have read and understand all program rules and responsibilities. I understand I must sign and return this form as a condition of employment in this program, and that I cannot begin working until this form is completed and returned to 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 o may result in termination of this agreement and payment for employment to any Medicaid Recipient of this program.

By signing below, I authorize PPL to process payments owed to me for services authorized by a FL PDO Program. Per my request, PPL will deposit my payment directly to my Debit Card or directly into my bank account using Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify I have read and agree to comply with PPL rules governing payments and electronic transfers. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL

Participant/Representative Signature _____ **Date**_____

Participant/Representative Name (Please Print) _____

Direct Service Worker Signature _____ **Date**_____

Direct Service Worker Name (Please Print) _____