FL Participant Direction Option, Florida Community Care
Worker Information and Attestation

To complete enrollment and be paid, Florida Community Care PDO program must get back all 10 pages of this Worker Information and Attestation form filled out with your information, all questions answered and signed and dated. When all pages are filled out please send to Florida Community Care PDO, through Public Partnerships LLC (PPL), the agency for your participant. Please fax to 1-855-879-7816 or email flfccpdo@pcgus.com.

Participant/Employer Information	
Participant First Name:	**Participant Last Name:**
Employer First Name:	**Employer Last Name:**

Worker Information		
Worker First Name:	**Worker M.I.:**	**Worker Last Name:**
Have you ever used an Alias? ☐ **Yes** ☐ **No**	**Worker Maiden/Alias Name(s):**	
Date of Birth:	**Social Security Number:**	**Gender:** ☐ Female ☐ Male

Relationship to Participant:	☐ **Parent/Step-Parent**	☐ **Child**	☐ **Sibling**	☐ **Grandparent**
☐ **Grandchild**	☐ **Spouse**	☐ **Legal Guardian**	☐ **Non-Relative**	☐ **Other**

Physical Address			
Physical Address (do not use P.O. Box):			
Physical Address 2 (apt, bldg., unit, ste.):			
City:	**State:**	**Zip Code:**	**County:**

Mailing Address *(if different from Physical Address)*		
Mailing Address:		
Mailing Address 2 (apt, bldg., unit, ste.):		
City:	**State:**	**Zip Code:**

Participant Name	Employer Name	Provider Name

Contact Information	
Preferred Method of Contact: ☐ **Home Phone Number** ☐ **Mobile Phone Number** ☐ **Email Address**	
Home Phone Number:	**Mobile Phone Number:**
Public Partnerships LLC has permission to text me using the mobile phone number above (carrier charges may apply): ☐ **Yes** ☐ **No**	
Email Address:	

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

Criminal Background Check Application Information

City of Birth: ______________ State/Province of Birth: _________ County (if known): _______________

Country of Birth: __________________________ Country of Citizenship: ____________________

Race: *(check one)* ☐ American Indian and/or Alaskan ☐ Asian or Pacific Islander ☐ Black ☐ Caucasian/Latino ☐ Unknown

Ethnicity: *(check one)* ☐ Non-Hispanic ☐ Hispanic ☐ Unknown

Eye Color: *(check one)* ☐ Black ☐ Blue ☐ Brown ☐ Green ☐ Gray ☐ Hazel ☐ Maroon ☐ Pink ☐ Multi-Colored ☐ Unknown

Hair Color: *(check one)* ☐ Bald ☐ Black ☐ Blonde ☐ Blue ☐ Brown ☐ Green ☐ Gray ☐ Orange ☐ Purple ☐ Pink ☐ Red ☐ Sandy ☐ White ☐ Unknown

Preferred Language: (*check one)* ☐ English ☐ Spanish

Height: ___________ Feet ______________ Inches Weight (Pounds): _________________

Participant Name	Employer Name	Provider Name

Application for Difficulty of Care
Federal Income Tax Exclusion

Certain payments received a worker for providing Medicaid services in the participant's home are considered Difficulty of Care payments and federal income tax will not be taken out of your pay for those services. To see if you qualify do the following steps. If you qualify the Florida Community Care PDO program will not report your pay as income and will not take out federal income taxes.

STEP 1: Read the information about the Difficulty of Care Federal Income Tax Exclusion. You can read the information at: https://www.publicpartnerships.com.

STEP 2: Check all that apply:

☐ **I provide services to the participant in my home.**
(NOTE: The participant receiving care must live in the same home as the participant care provider, regardless of who owns the 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 the above do not apply, you are not eligible for the Difficulty of Care Federal Income Tax Exclusion.

STEP 4: If all the above apply, you are eligible for the Difficulty of Care Federal Income Tax Exclusion.

Under penalties of perjury, I swear that I am a worker receiving pay from a state Medicaid Home and Community-Based Services program. I live with and provide care to the participant.

IMPORTANT: If you no longer live with the participant you take care of, you must tell the Florida Community Care PDO program through Public Partnerships and you will pay federal taxes on the Difficulty of Care services you do.

Participant Name	Employer Name	Provider Name

Payment Information

(If a payment selection is not checked, the Florida Community Care PDO program will send your payments by debit card)

Payment Selection: *(check only one box)* ☐ Direct Deposit ☐ Money Network Card

Direct Deposit

Account Type: *(check only one box)* ☐ Checking Account ☐ Savings Account

Account Information

1. If you pick **Money Services Network Debit Card**, you do not need to give more information in this section. To learn more about Money Services Network Debit Card, please refer to the DSW Informational Packet.
2. You can stop direct deposit by calling customer service. If you are changing your bank account information, this form must be sent in.

Banking Institution Name	
Routing Number	☐☐☐☐☐☐☐☐☐
Account Number	☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Account Nickname (if desired)	

Pay Stub/Remittance Advice

GO GREEN: PPL makes your pay stub available on our BetterOnline™ web portal. If you do not have access to the internet through a computer, tablet, or smart phone, then check the box below.

☐ **I do not have access to the internet, please send my pay stub in the mail.**

Timesheet Submission

The best way to submit time worked to the Florida Community Care PDO program is online, using e-Timesheets on the BetterOnline™ web portal or on your smartphone using the Time4Care™ smartphone application.

Submitting time through e-Timesheets or Time4Care™ lets you fill out and submit timesheets online, see the status of payments, and search for timesheets previously entered and paid in the system. All of this can be done at your convenience, so you do not have to call Public Partnerships LLC customer service to see if your timesheet was received.

☐ **I am unable to complete my timesheets electronically and will use paper timesheets for my time submission.**

Participant Name	Employer Name	Provider Name

Relationship Questionnaire

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 providing domestic services?

☐ **YES**, that description fits my status. ☐ **NO**, that description does not fit my status.

2. Are you the child of the participant (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 participant?

☐ **YES**, my employer is my spouse (husband, wife or domestic partner). ☐ **NO**, my employer is my spouse.

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

☐ **YES**, my employer is my child (son or daughter). ☐ **NO**, my employer is my child.

5. If you answered, "<u>YES</u>," to Question 4, check any of the following that apply.

☐ **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 weeks in a row during the calendar quarter in which services are performed.

☐ **YES**, my child (son or daughter) is widowed, divorced, not remarried or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed.

☐ **NO**, none of the above apply.

6. Are you under the age of 18 or do you turn 18 before December 31?

☐ **YES**, I am under 18 or am turning 18 **before December 31** ☐ **NO**, I am over 18.

*If you answered, "**<u>YES</u>**," to Question 6, answer the following question. If you answered, "**<u>NO</u>**," skip the question 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,** this is my main job. ☐ **NO,** this is not my main job.

Participant Name	Employer Name	Provider Name

Direct Service Worker (DSW) Pay Rate *Indicate which services will be provided by checking the boxes that apply.*		
Service Name	**Service Code**	**Hourly Rate**
☐ **Adult Companion Care** 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.	S5135CG	$
☐ **Attendant Nursing Care** 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.	S5125CG	$
☐ **Homemaker Services** 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.	S5130CG	$
☐ **Personal Care Services** A service that aids 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.	T1019CG	$

☐ **Intermittent-Skilled Nursing (RN)**	T1002CG	$
☐ **Intermittent-Skilled Nursing (LPN)**	T1003CG	$

Participant Name	Employer Name	Provider Name

Intermittent-Skilled Nursing Services
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 need is predictable.

Direct Service Worker Schedule
As the worker, I know that in the Florida Community Care PDO program my participant will set my schedule for when I can work.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Direct Service Worker Qualifications
As the worker, I know that if I provide services in the Florida Community Care PDO program I must meet the following qualifications.

1. 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.

If I am hired to perform Nursing Services in **Intermittent and Skilled Nursing**, I 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.

Mutual Responsibilities

The parties will the policies and procedures of the Florida Community Care PDO program . The worker and participant or Authorized Representative will hold harmless, release, and forever discharge the Florida Community Care PDO program and Public Partnerships LLC from any claims and/or damages that might arise out of any action or omissions by the worker or participant.

Worker Acknowledgement

I acknowledge the following:

1. I am a worker of the participant and do not work for Public Partnerships or Florida Community Care PDO program or the state of Florida.
2. This agreement does not promise a certain number of hours of work and does not keep my participant from hiring other workers.
3. I cannot work and be paid for more hours than the allowed per day.
4. I can only work for one participant at a time.

Participant Name	Employer Name	Provider Name

5. Any information shared with me by my participant or the Florida Community Care PDO program and affiliated agencies must kept private.
6. I will carry out assigned duties and jobs explained to me by my participant
7. I am to be dependable and be at work on time.
8. I can only use my participant's personal things if we both agree it is alright.
9. I must be 18 years or older to work for my participant.
10. I will call my participant as soon as possible if I am sick or will not be at work on time .
11. I will give my participant two weeks' notice if I decide to quit this job.
12. I will let the participants Case Manager know if I cannot get a hold of my participant.
13. My participant will tell me when I can work and what I will be doing if I am hired and can fire me if they want to.
14. My participant will fire me right away if :
    - (1) I am found on a Disqualification Registry or List maintained by the Florida Community Care PDO program or OIG,
    - (2) I abuse, neglect, or misuse funds or property of the participant,
    - (3) I commit fraud or violate the terms of this Agreement.
15. I will have a Level 2 criminal background check through Florida's Agency for Health Care Administration before I am hired, and the results of the criminal background check may be shared with the Florida Community Care PDO program and/or my participant.
16. I know I cannot start my job until I have passed the criminal background check, and my participant has received a "Good to Go" notice from Florida Community Care PDO program through Public Partnerships.
17. I must report possible neglect, abuse or misuse of funds or property to the participant's Case Manager right away. I can also call the Florida Abuse hotline at 1-800-96-ABUSE (22873).
18. I will be paid by Florida Community Care PDO program through Public Partnerships once every two weeks, after we turn in a true and approved timesheet.
19. I cannot turn in a timesheet if :
    - (1) my participant does not have Medicaid anymore,
    - (2) for jobs or hours not allowed on my participant's care plan, or
    - (3) work before my participant gets "Good-to-Go" notice from Florida Community Care PDO program through Public Partnerships.
20. I will not be paid when my participant is hospitalized, or I do other work not allowed on the participant's care plan.
21. I will let the Florida Community Care PDO program through Public Partnerships know if or when my address or personal information changes or if I want to change how I am paid or change my tax withholdings
22. I know that I am paid with federal and/or state funds. True and correct information is expected. Not doing this is breaking the law.
23. I know that I cannot be paid for work I did not do. I know that if I am I will have to pay it back. The withholding process will be overseen by appropriate law. Florida Community Care PDO program through Public Partnerships will pursue all legal means to recover the amount of overpayment.
24. Medicaid Fraud is a felony and can lead to large penalties and/or jail time. I can report any suspected fraud to the PPL Enrollment Specialist and/or the Florida Medicaid Fraud Unit at 1-888-419-3456.

Participant Name	Employer Name	Provider Name

Participant Acknowledgement

I acknowledge the following:

1. I know my worker works for me and does not work for Public Partnerships or the Florida Community Care PDO program or the state of Florida.
2. I must let the Florida Community Care PDO program , through Public Partnerships know if I decide to fire any of my workers.
3. I know I must fire my worker right away if:
   - (1) they are on a Provider Disqualification Registry or List maintained by either the Florida Community Care PDO program or OIG,
   - (2) have committed abuse, neglect, or misuse of my funds or property, or
   - (3) have committed fraud or violated the terms of this Agreement.
4. I must report possible neglect, abuse or misuse of funds or property to my Case Manager right away. I can also call the Florida Abuse hotline at 1-800-96-ABUSE (22873)
5. I know my worker is not allowed to begin working until they pass the background screening and I have a "Good to Go" notice from the Florida Community Care PDO program, through Public Partnerships.
6. I know the Florida Community Care PDO program , through Public Partnerships will pay my worker for me once every two weeks, after we turn in a true and approved timesheet.
7. I know that my worker may not turn in timesheets if:
   - (1) I do not have Medicaid anymore,
   - (2) the worker does any jobs or has hours that are not allowed on my care plan, or
   - (3) the worker begins working before I get a notice of “Good-to-Pay” from the Florida Community Care PDO program through Public Partnerships
8. I know to notify the Florida Community Care PDO program through Public Partnerships if or when my address or personal information changes.
9. I know my worker will not be paid when I am in the hospital or for other work not allowed on my care plan.
10. My worker will not get paid if I no longer have Medicaid. If my worker is paid, then I will need to pay back the monies that my worker received.
11. I know my worker is paid with federal and/or state fund. I cannot approve timesheets that are not true. If I am not truthful and it is found out, then I will be charged and prosecuted under the law.
12. Medicaid Fraud is a felony and can lead to large penalties and/or jail time. I can report any suspected fraud to the PPL Enrollment Specialist and/or the Florida Medicaid Fraud Unit at 1-888-419-3456.

Attestation

By signing below, my employer and I confirm that:

- We have read and understand all program rules.
- Some wages paid to a worker while working in the worker’s home are “Difficulty of Care” wages. Federal income tax is not collected from these types of wages. Some workers in this program are fit for this “Difficulty of Care” income tax exclusion.

Participant Name	Employer Name	Provider Name

- I also agree I filled out the Relationship Questionnaire to show my relationship to my participant. The program will use this to collect my FICA taxes. If wrong data in the Relationship Questionnaire or Difficulty of Care Federal Income Tax Exclusion causes too little tax to be collected, it is my duty to pay the tax due.
- I must sign and return this form to work in Florida Community Care PDO program.
- I know what I will be asked to do, and I have agreed to these terms and conditions.
- I further know and agree that violation of any of the terms and/or conditions may result in termination of this agreement.
- I know that to have this job I must have a level 2 criminal background check and be found Eligible.
- I have completed the USCIS Form I-9, as defined in Instructions for Employment Eligibility Verification by the Department of Homeland Security. The Florida Community Care PDO program, through Public Partnerships provides the Form I-9 in the employment packets, and the participant keep the original Form I-9 and forwards a completed copy to the Florida Community Care PDO program, through Public Partnerships; which Public Partnerships will keep in the worker's files.
- I have made a direct deposit payment selection. I authorize the Florida Community Care PDO program, through Public Partnerships to process payments owed to me for services authorized by the Florida Community Care PDO program. Public Partnerships will deposit my payment directly into my bank account using Automated Clearing House (ACH) transaction.
- If I fail to provide complete and correct information on this form, payment processing may be delayed or made impossible. I certify that I have read and will comply with rules governing payments and electronic transfers.
- I authorize the Florida Community Care PDO program through Public Partnerships to withdraw from my account all amounts deposited electronically in error. If my account is closed or has an insufficient balance to allow withdrawal, then I authorize the Florida Community Care PDO program, through Public Partnerships to withhold any payment owed to me by Public Partnerships until the wrong amounts deposited are paid back. If I decide to change or end this deposit authorization, I know that I must send a notice to the Florida Community Care PDO program, through Public Partnerships.

____
Participant (Authorized Representative) Name

____
Participant (Authorized Representative) Signature (Date)

____
Worker Name

____
Worker Signature Date