Kentucky Participant Directed Services (PDS)
Employee/Provider Contract

I (*employee name)* _____, last four of Social Security Number_____ have agreed to work under the employment of *(employer name/waiver participant name)* _____ Medicaid ID_____.

I understand that, as a waiver participant, I can choose a PDS representative to help me with my responsibilities as an employer.

Participant Directed Services Representative Name (if applicable) _____.

Financial Management Agency Name _____.

Case Manager Agency Name _____.

Services delivered under this contract will consist of the following:

Service Provided	Service Code	Rate Per Hour	Hours Per Week	Anticipated Start Date*	End Date**

**Anticipated start date should reflect the date services are anticipated to begin.*
*** Only complete end date if the employee stops providing the service.*

Please see the attached list for a list of services available via PDS. For a full waiver service listing and max rates, please see the Home and Community Based Services Waiver Rates document on https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

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As the employee:

- [ ] I agree to provide the services as specified by my employer (the waiver participant) as defined in the table above.

- [ ] I understand civil or criminal penalties can be pursued and termination from employment can occur if allegations of fraud against the Department for Medicaid Services are substantiated.

- [ ] I understand that I shall not be allowed to provide services based on the results of my background check, all applicable screenings and/or failing to complete trainings/certifications required by my employer (the waiver participant).

- [ ] I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers Compensation (KRS Chapter 342) shall not apply to my employment as a PDS employee. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor case manager can be held liable for any injuries or losses I may incur while providing services.

- [ ] I understand that I must maintain employee/employer confidentiality.

- [ ] I understand this is an at-will contract and either party may terminate this agreement at any time.

- [ ] I understand that I must notify my employer (the waiver participant) of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

- [ ] I agree to follow all relevant state and federal statutes and regulations, including the use of Electronic Visit Verification.

- [ ] I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer (the waiver participant) and myself.

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As the employer (waiver participant):

- ☐ I understand that I may be responsible for wages for my employee should my employee or I not provide employee qualifications by the respective deadlines.
- ☐ I understand that I can only require my employee to assist with duties that are relevant to my needs and outcomes that are specified on the Person-Centered Service Plan for Medicaid payment.
- ☐ I understand that I may be responsible for payment for any hours I may require my employee to work beyond any prior authorization limits or waiver regulation guidelines.

_____
Employee Signature Date

_____
Employer/Participant Date

_____
PDS Representative (if applicable) Date

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Waiver Services Available via PDS		
Waiver Program	**Service**	**Code**
ABI Acute	Companion	S5135 HI
ABI Acute	Personal Care	97535 HI
ABI Acute	Respite	T1005 HI
ABI Acute	Supported Employment	H0039 HI
ABI LTC	Community Living Supports	97535 HI
ABI LTC	Respite	T1005 HI
ABI LTC	Supported Employment	H0039 HI
HCB	Attendant Care	S5108 HI
HCB	Non-specialized Respite	T1005 HI
MP	Attendant Care	S5125 HI
MP	Community Living Supports	97535 HI
MP	Homemaker	S5130 HI
MP	Personal Care	T1019 HI
MP	Respite	T1005 HI
MP	Supported Employment	H0039
SCL	Community Access	97535 HI
SCL	Community Access Group	97537 HI
SCL	Community Guide	H2015 HI
SCL	Personal Assistance	T1019 HI
SCL	Respite	T1005 HI
SCL	Supported Employment	T2019 HI