Frequently Asked Questions

1. What is PDS?
   PDS stands for Participant Directed Services. PDS is considered an alternative to *traditional services*. PDS is a way in which a participant can be named an *Employer of Record*; as this the participant chooses who can provide personal needs assistance as an employee, *if eligible*. The employer of record is primarily responsible for recruiting, interviewing, hiring, training, scheduling times for work, setting job wages, providing job descriptions, evaluating employees' performance, and termination as necessary. In addition, a participant may utilize PDS to choose their own goods, equipment, and/or modifications if approved.

2. What is blended services?
   This means that a participant receives one or more services through a traditional provider, such as an adult day center or Home Health agency, and then receives one or more services through Participant Directed Services, such as Respite or Goods and Services.

3. If a participant chooses PDS but may not be capable of managing the services, is the participant still eligible?
   Yes. The participant may appoint a *Representative* to act on their behalf. This representative shall be in charge of overseeing all the duties that the Employer of Record would do.

4. What else can a representative do for a participant?
   If a representative is appointed, that representative cannot be a paid employee for any service for that same participant. However, a representative can be an employee for another participant, *if eligible*, or be another representative for another participant.

5. Can a Community Guide be an employee of other services?
   Not to the same participant, but may eligible to be an employee of another participant.

6. Can a person be Community Guide for more than one participant?
   Yes.

7. Can a participant have both a representative and Community Guide?
   Yes; the team would need to be certain to illustrate exactly what duties would be performed by each person.

8. Can a case management agency also provide Community Guide services to the same participant?
   No.

9. Who would review the MAP 532 (family exemption form) and how long is the turn around time?
   This would be submitted to DAIL; DAIL has 14 days to respond.

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10. Who is considered an immediate family member?
    This is defined by KRS 205.8451(3) as a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild.

11. Does training certification from College of Direct Supports (CDS) carry over to any other consumer or agency an employee applies to?
    Yes; the employee has an account and certification that is valid with any employer for SCL.

12. Where does the employee complete the CDS training?
    This can be done at the case management agency, at the participant's home, or anywhere the employee can access CDS online. A case management agency has a sub administrator that will provide the employee with account access.

13. What convictions cause an employee candidate to be ineligible?
    A person cannot be convicted of any drug related crime in the last 5 years, cannot be convicted of a violent crime or sex crime as defined in KRS 17.165(1) through (3), which involves a Class A or Class B felony involving the death of a victim, rape in the first degree or sodomy in the first degree, or serious physical injury.

14. What happens when a candidate has any of these convictions or is found substantiated on an abuse report?
    The case manager would inform the participant that the candidate is not eligible and must find a replacement.

15. What happens if an employee fails to pass the CPR/FA course?
    The employee would be ineligible for timesheet payment through PDS until passing the course.

16. When can an employee start working?
    An employee must complete certain requirements before starting; this includes the ***Nurse Abuse Registry*** background check, the ***Administrative Office of the Courts*** criminal background check, ***Tuberculosis (TB)*** screening, and a ***five (5) panel drug*** test. Once started, an employee has thirty (30) days to complete the ***Central Registry*** background check, and six (6) months to complete the ***College of Direct Supports*** training, ***CPR/First Aid*** certification and any other training required by the employer of record. If a potential employee has lived in any other state within the last year, then each equivalent background check has to be obtained from each state. If an employee does not get these requirements completed within the specific times, then the employee shall not be eligible for payment from Medicaid.

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17. What is Personal Assistance?
    This service is what most formerly would know as CLS. The participant may be provided assistance with personal care duties, along with homemaking, personal money management, leisure activities, community choices such as shopping and dining, and assisting with medical care including being accompanied to skilled professional appointments.

18. What is community access?
    This service is designed to assist the participant become connected with community groups or organizations, such as groups within churches, book clubs, YMCA activities, etc., and includes the employee providing guidance and insight to the members of those chosen clubs to assist the participant to integrate into those clubs. The intent with this service is to have the participant make a strong enough connection with members in order to get members to reach out to the participant and assist with personal assistance with at these venues, or to assist with transportation to and from club activities. Once this connection has been established, the case manager would look to phase this service out of the plan of care.

19. How long is community access authorized for?
    6 month intervals.

20. What is a Financial Management Agent (FMA)?
    FMA is an agency that provides financial services on behalf of the participant. As an employer of record, the participant incurs taxes that must be paid in order to remain an employer of record, along with maintain at least one (1) employee to provide services. The FMA is responsible for paying employer taxes to the federal, state, and possible local authorities on behalf of the participant; the FMA also process employee taxes on behalf of the employee to those same federal, state, and local authorities. Once a timesheet has been processed, the FMA will issue a paycheck to the employee for the time submitted.

21. Who can a participant choose as an FMA to provide these financial services?
    A participant may choose either an Area Agency on Aging (AAA) or a Community Mental Health Center (CMHC) to provide financial services. While these agencies have certain counties they serve, they are eligible to serve in other regions in a participant chooses. A list of these agencies is posted on our website.

22. Is it possible to avoid any taxes as an employer or employee?
    Yes; the case manager would need to consult with the FMA that the participant has chosen in order to determine which special tax exemptions may apply to the participant and/or employee.

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23. How are these taxes paid?
    The FMA is able to generate a percentage that must be placed on top of an employee's wages in order to claim funds to make payments to these tax authorities. The FMA will deduct a specific percentage from the reimbursed claim that Medicaid has provided to the FMA, and submit the rest of the claim towards employees for payment. **All** claims for services provided are dedicated to invoices, timesheets, and/or taxes. **None** of these dollars are available to the FMA or case manager.

24. What else does the Financial Management Agent do for a participant?
    The FMA will also complete expenditure reports that will be submitted to the case manager to show the Plan of Care is being used through timesheets that are processed. They will also provide an employer packet to the case manager with the forms that are necessary for enrollment, such as employer tax forms, payroll processing policies, a schedule of the calendar work week, and pay period deadlines.

25. What will the expenditure report look like?
    The FMA will be able to show how many units of services are authorized, whether weekly or monthly, what has been spent for a given period and what is remaining. The report will not contain any dollar figure associated with payroll distributed or funds remaining in the Prior Authorized units.

26. Is there a conflict of interest if the financial management agent and the case management agency are the same agency?
    No; the FMA receives no more or less benefit regardless of which case management agency is chosen by the participant.

27. What if an employee submits timesheets more than one month after services have been provided?
    The case manager would generate a Corrective Action Plan due to the case manager not being able to properly monitor the health, safety, and welfare of the participant.

28. Does the FMA need page two (service documentation) of the timesheet to verify services?
    No, only page one is necessary for the FMA. The FMA understands that once the first page is submitted, that the service documentation matches the services and hours provided.

29. Does an employee complete a monthly summary every month?
    No, the monthly summary is not required of PDS employees.

30. Can an employee work more than forty (40) hours per week?
    It can **only** be considered in an *emergency*. An emergency would be considered a situation

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where an employee could not be relieved from working, such as a person designated in the safety plan or in the narrative is unavailable, and if no other employee is available to relieve the current worker; the case manager shall decide if the overtime is justified. Medicaid will only pay straight time for any emergency hours submitted over 40; the employer of record shall be responsible for any additional payments that may be requested by the employee for overtime.

31. If someone needs more services and/or new services, what is the process to get those authorized?
    The case manager would update the plan of care requesting the additional units and/or services, submit to Carewise Health, and Carewise will authorize additional units and/or services that fit regulation parameters. Any requests that go beyond regulation parameters would need to show *Exceptional Supports Protocol* approval for processing.

32. How far back will Carewise recognize an Exceptional Rates Protocol request?
    Only from the date of reception; once a case manager identifies an exceptional rate is necessary, the case manager would need to initiate the request promptly to further ensure proper coverage.

33. Who can receive natural supports training?
    Anyone who is involved with the participant.

34. Who may train others in natural supports training?
    Anyone other than immediate family members, guardians, or legally responsible individuals.

35. How are incident reports handled?
    Once an event is reported to the case manager, the case manager can deem this the discovery of an incident. From there, the case manager would follow the incident reporting protocol.