North Carolina Innovations Waiver

Employee Agreement

Name of Participant (please print) _____

Name of Employee (please print) _____

Employee Address _____

_____

Employee Gender _____ **Employee Phone** _____
Male/Female

Employee Email _____

Please check one: □ **Existing Employee** □ **New Employee**

- ☐ ***None***, no relation to employer
- ☐ ****Spouse*** of the employer,
- ☐ ****Child*** of the employer and under the age of 21
- ☐ ****Parent*** of the employer - if this option is marked, read below and check all that apply:
  - ☐ ***You are employed by your son or daughter***
  - ☐ ***Your son or daughter has a child or stepchild living in the home***
  - ☐ ***Your son or daughter is a widower, divorced, or is living with a spouse who, because of a mental or physical condition, cannot care for the child or stepchild for at least 4 continuous weeks in a calendar quarter***
  - ☐ ***Your son or daughter's child or stepchild is under the age of 18 and requires the personal care of an adult for at least 4 continuous weeks in a calendar quarter due to a mental or physical condition***

*Internal Use Only
• If Parent (employee) selected all 4 parent conditions, parent/employee is **FUTA and SUTA Exempt** • If Parent (employee) did **NOT** select all 4 parent conditions, parent/employee is **FICA, FUTA, SUTA Exempt**
• If Spouse or Child are selected, employee is **FICA, FUTA, SUTA Exempt**

The employee agrees to accept payment for services provided for individuals served through North Carolina's Innovations Waiver. Fiscal management services are provided by Acumen Fiscal Agent, LLC, which is not a North Carolina government agency. Acceptance and endorsement of payment will signify that the employee agrees to the following terms and conditions:

1. I understand and acknowledge that the participant or the participant's representative is my employer. My employer is not Acumen, the State of North Carolina, an LME-MCO or any other entity involved with this Employer of Record (EOR) program through the Innovations Waiver.
2. I accept payment as payment in full for the services provided. I cannot accept any additional compensation for the hours I have worked.
3. I will provide only the services that have been approved by my employer and authorized in the participant's Individualized Support Plan.
4. I understand I will be required to accurately complete and submit my time worked through the Acumen DCI/Web Time Entry (WTE) portal on a timely basis, as outlined in the Payment Schedule provided to me. I understand that failure to submit my time worked on time will result in the delay of compensation for the hours I have worked.

5. I will provide the LME-MCO or its designee information regarding the service(s) provided for which payment was made, upon request.
6. I recognize that employment is dependent on the employer's participation in the Innovations Waiver EOR program.
7. I will immediately notify a person designated by the employer of any participant medical emergency, illness, or visit to a physician.
8. I will take part in any meetings if requested by and/or regarding the participant.
9. I understand and consent to having a criminal background check completed on me. I understand that my employment may be contingent on the results of this check in accordance to all applicable laws, rules and policies.
10. I understand and agree to disclose any criminal conviction that may occur during the time of employment in this program.
11. I understand and consent to having a Medicaid List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED) background check completed on me. I understand that my employment is contingent on the results of this check in accordance to all applicable laws, rules and policies.
12. I understand and consent to having a Health Registry Check completed on me. I understand that my employment is contingent on the results of these checks in accordance to all applicable laws, rules and policies.
13. I understand and authorize the LME-MCO and Acumen to provide my employer the results of all background checks completed on me for this Innovations Waiver EOR program.
14. I agree to complete all required paperwork and be approved prior to providing any services under the Innovations Waiver EOR program.
15. I understand that I may have access to confidential information about the participant and that I am not to repeat this information to anyone other than the participant or the participant's designee.
16. I understand and acknowledge that any untruthful submission of services provided in an attempt to obtain improper payment is subject to investigation as fraud.
17. I understand that I am required to report the abuse or neglect of any individual participating in the North Carolina's Innovations Waiver to the participant's care coordinator.
18. I acknowledge that I have the necessary skills, knowledge and experience; and have received sufficient training and orientation to meet the support needs of the participant. I will inform my employer if I feel I need more orientation and/or training to meet the support needs of the participant.

By signing below, I acknowledge that I have read this employee agreement in its entirety (2 pages). I understand that I must sign and return both pages as a condition of employment in this program and that I cannot begin working in this Innovations Waiver EOR program until this form is completed and returned to Acumen Fiscal Agent. I further acknowledge by signing below, that I understand what is being required of me, and agree to abide by its 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 recipient of this program.

Employee Signature *Date*

Participant/Employer or Representative Signature *Date*