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South Dakota Family Support 360
Self-Directed Option Employee Agreement

Name of Participant _____ **Medicaid ID #** _____
Participant Name (Print)

Name of Employee _____
Employee Name (Print)

Employee Address _____

_____

Employee Phone _____ **Employee Email** _____
Phone Number (include area code) Email Address

The employee agrees to accept payment for services provided for individuals served through the South Dakota Family Support 360 Program. The participant's FEA is not a South Dakota government agency. Acceptance and endorsement of payment will signify that the employee agrees to the following terms and conditions: **Please initial by each number:**

1. _____I understand and acknowledge that the Participant or their representative is my employer. My employer is not the Participant's FEA, the South Dakota Family Support 360 Program or any other entity involved with this Self-Directed Employer Option.

2. _____I accept payment from my Participant's FEA 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 Budget/Spending Plan.

4. _____I understand that as the employee providing service, I am responsible to submit service documentation upon time entry to include the following:
   i. Description of various covered activities (services) involving the participant receiving services,
   ii. Record of situations or incidents (good or bad) that arise affecting the participant receiving services,
   iii. Ensure service documentation is completed at the time of service.

5. _____I will provide the Department 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 Participant's participation in the South Dakota Family Support 360 Self Directed Employer Option.

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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 the following criminal checks completed when required: South Dakota Department of Health Services criminal background check and/or a national criminal background check. I understand my employment is contingent upon receiving the result of my background check(s) in accordance with all applicable laws, rules and policies.

10. _____I understand that the results of my background checks will be made available to my prospective employer and other program staff as necessary and/or required.

11. _____I agree to complete all required paperwork and be approved prior to providing each service(s) requested under this self-directed program.

12. _____I understand and acknowledge that any untruthful submission of services provided in an attempt to obtain improper payment is subject to investigation as Medicaid Fraud. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.

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 the Self-Directed Employer Option Family Support 360 program until this form is completed and returned to my Participant's FEA. I further acknowledge by signing below, that I understand what is 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 Medicaid Recipient of this program.

Employee signature Date

Employer/Participant signature Date