Utah Aging
Employer/Acumen Agreement Form

This Agreement is between Acumen Fiscal Agent, LLC. and the Employer as stated below.

General understanding and conditions of the Self-Directed option through the Bear River Association of Governments, Davis County Senior Services, Five County Association of Governments, Mountainland Association of Governments, Salt Lake County Aging & Adult Services, Six County Association of Governments, Tooele County Aging and Adult Services, Uintah County Golden Age Center and Weber-Morgan Human Services programs:

- Participation in this Self-Directed option is a decision I have made after consultation with the Case Manager.

- I have received from the Case Manager any/all program related information about the service delivery options and the rules and regulations regarding participation in the Self-Directed option. I understand it is my responsibility as the Employer to abide by all the rules and regulations of the program.

- I understand that I am the Employer of Record for this program. The employer is not Acumen Fiscal Agent (Acumen) or the Self-Directed option program in which I am associated with. I understand that as the employer of record I am responsible to comply with paying all of my employees in accordance with the Department of Labor Regulations including the Fair Labor Standards Act and Final Rule. Furthermore, I understand that this employer responsibility may extend beyond what the program funds may pay my employee and I accept full responsibility for all debts owed.

- I understand it is my responsibility to hire and train only qualified providers/employees, as defined by the Self-Directed program, to furnish my services.

- I understand I will be provided with enrollment materials and guidance on the requirements to complete each form. It is ultimately my responsibility as the employer to ensure all forms that my employee and/or I complete are correct within required guidelines.

- I will not allow provider(s)/employee(s) to begin performing work until I have been notified that provider(s)/employee(s) are active in the system (Good to Go).

- I understand that if the program requires my employee (job applicant) to pass a background check I will ensure all investigation reports are kept confidential, and will not be shared, and will be disposed of properly given that they include sensitive data (e.g. criminal history) and personally identifiable information (e.g. name, date of birth, SSN).

- I understand that Acumen is only authorized to represent me in processing payments as it relates to this Self-Directed option and will only make payments on my behalf in accordance to the authorized amounts as outlined in my Service Authorization.

- I understand it is my responsibility to stay aware of any remaining balances and schedule provider(s)/employee(s) and/or request program payments within those available hours.

- I understand that if I cause work to happen above and beyond what is authorized in the Service Authorization, I, as the employer, will be personally responsible for those expenses.

- I understand it is my responsibility to review and approve all requests for payment prior to submitting them for payment to ensure accuracy and confirm they are authorized for processing.

- I understand that, on occasion, I may receive automated (general announcement) communication from Acumen regarding important program and/or payroll information as it relates only and specifically to the Self-Directed program.

- I understand that Acumen will provide a Workers' Compensation poster in the event my employee is injured on the job. I understand this poster must be displayed in the home where services are provided and in an area where it can be easily viewed and read by my employee during their work hours.

- I understand it is my responsibility to notify the Case Manager immediately of any significant changes in circumstances that may affect the Client's Service Authorization and/or safety.

- I understand it is my responsibility to notify the Case Manager immediately of any changes that effect eligibility for Self-Directed services. (e.g. loss of approved funds, hospitalization, placement in a facility) I understand I may be responsible for payment of any work performed during the loss of eligibility.

- I understand all requests for payment must have an employer signature and date indicating approval**.** I understand that Acumen will not process a payment request without proper employer and/or Case Manager approval.

- I attest that I will submit and/or approve all payment requests in accordance with the Program regulations. I understand that payment and satisfaction of my claims may be from Federal and State funds, and that I may be prosecuted under applicable Federal or State laws, for any false claims, statements or documents or concealment of a material fact. Any misuse of funds may result in being fined or penalized including but not limited to my repayment of claim. Any collection costs or legal fees will be my responsibility to pay.

My signature below confirms my understanding and agreement to abide by the terms and conditions as stated above.

Name of Client: _____

Name of Employer: _____

Phone: _____

Email Address: _____

_____ _____

Employer Signature Date

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