IDAHO DEPARTMENT OF HEALTH & WELFARE

Family-Directed Community Supports Option

MEDICAID – COMMUNITY SUPPORT WORKER AGREEMENT

This agreement is hereby made between the Family-Directed Community Supports (FDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and

_____,
a Community Support Worker (CSW).

This CSW is associated with an Agency. ☐ Yes ☐ No.

The CSW acknowledges that even though he/she is the employee of a participant in the FDCS Option, the Department, through the Fiscal Employer Agent (FEA) is the source of payment for the CSW's wages for services performed under the FDCS Option. Because of the unique relationships of the participant, the Department, and the FEA the CSW acknowledges and agrees to the following:

1. Services provided to any participant under the FDCS Option will be provided in compliance with the rules contained in IDAPA 16.03.26 Section 800-846., "Consumer-Directed Community Supports."

. Payment will not be requested through the FEA or the Department or any service not performed in accordance with the DCS rules, the employment agreement with the participant or the participant's Support and Spending Plan. It is understood that neither the FEA nor the Department is liable to pay for any service performed that is not in conformance with the FDCS rules, the employment agreement with the participant, and the participant's Support and Spending Plan.

3. The CSW acknowledges that even though he/she is the employee of the Participant, they are also a Medicaid provider under the FDCS Option. As a provider the CSW agrees to accept payment received by the FEA as payment in full for services rendered under the FDCS Option.

4. The CSW acknowledges they are an employee of the participant and not an employee of the Department or the Fiscal/Employer Agent (F/EA) and agrees that the CSW is not entitled to nor will make claim for any employee benefits from the Department of the FEA, including but not limited to, workers' compensation, disability life and/or health insurance.

5. To protect the confidentiality of personal and health information relating to the participant and his participation in the Medicaid Option, and to release that information only on request of the participant or as otherwise allowed by law.

I have read the foregoing agreement, I understand it, and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms or conditions of this agreement or the rules may result in termination of this Agreement, and thereby the source of payment for my employment to any FDCS participant.

_____

Printed name of CSW

_____

Signature of CSW Date

Note: Each CSW must sign personally.