



Creating solutions, *One* person at a time

**VERIFICATION OF
RELATIVE/LEGAL GUARDIAN AS DIRECT SUPPORT EMPLOYEE**
This document is to be completed by PBH Network Provider Agency or Employers of Record as a part of their certification of compliance with the Innovations Relative/Legal Guardian as Provider Policy

Please note that parents, biological or adoptive, and step-parents cannot be employed to provide services to their minor children under the Innovations waiver.

Part A Application – New Employees

Please complete one application per prospective new employee. Part A applies to employees that are being newly interviewed. Use Part B for employees that were employed by your agency prior to the implementation of the Innovations Waiver Relative as Direct Support Employee Policy or have been previously certified through this process.

Section I

Date of Submission: _____

Participant Name: _____ Participants Age at Time of Application: ____

Date of Birth: / / dd / mm / yyyy **Note: This process applies to waiver participants who are 18 years of age or older**

Waiver Region that Participant's Medicaid originates from:

- PBH Alamance-Caswell Five County OPC

Name and address of Provider Agency or Employer of Record, include name address and phone number of Provider Agency QP or Employer of Record:

Prospective Employee: _____

Relationship to Consumer: _____

Legal Guardian Yes No

Does this Relative or legal guardian live in the same home as the waiver participant?

Yes No, **If no then this process is not required**

Section II

Which service (s) will be provided:

- Community Networking; How many hours per week/day? _____
- Day Supports; How many hours per week/day? _____
- Personal Care; How many hours per week/day? _____
- In-Home Skill Building (Individual); How many hours per week/day? _____
- In-Home Skill Building (Group); How many hours per week/day? _____
- Intensive In-Home Supports; How many hours per week/day? _____
- Residential Supports; How many units per week? _____

Will the relative or legal guardian be providing primary or back up services?

Who will provide Back-up Staffing? _____

If the person is the legal guardian what strategies is the Provider Agency going to employ to ensure that the decisions made by the employee are in the best interest of the waiver participant? _____

Section III

PBH must prior authorize the provision of services by a family member or legal guardian living in the same household as the waiver participant.

**As Provider Agency or Employer of Record, I am verifying the following:
(Please check each item verified and provide additional justification if requested.)**

- 1. The relative or legal guardian must meet the provider qualifications for the service.
(Response to a) is required. Response to b) and c) as appropriate to the individual's needs.)**
 - a) The prospective employee (relative or legal guardian) meets the provider qualifications for the specific service they are being interviewed/employed to provide. (To be verified by QM upon on-site review.)
 - b) If **medical tasks** are required to meet the individual's needs, the employee only performs tasks they are qualified to provide under the NC Nursing Practice Act. Please detail the tasks: _____
 - c) The provider certifies that there is documented training for the specific medical task by a professional appropriately qualified in the task or equipment and that the employee receives nursing supervision to carry out this function as specified by the NC Nursing Practice Act.

- 2. A qualified provider who is not a relative or legal guardian is:**
 - a) Not available to provide the service. Please describe:

Number of people interviewed and not hired for the position and the justification for not hiring each staff person

Total number interviewed: _____

Justification: (Please check all that apply and attach additional sheets if necessary)

- Did not have necessary skills (# interviewed: _____)
- Not available at the days/times/places necessary (# interviewed: _____)
- Difficulty with interpersonal relationships; please explain: (# interviewed: _____)

Staff not available due to remote location; please explain: (# interviewed ____)

Other; please explain: (# interviewed ____)

OR

b) A qualified provider is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the family member or legal guardian. Please explain: (e.g. specialized nursing training, holds a license in a field required for the service etc.)

3. The relative or legal guardian is not paid to provide any service that they would ordinarily perform in the household for an individual of similar age who does not have a disability.

4. The prospective employee is not the:

- Employer of Record or Managing Employer in an Agency with Choice model
- Respite Service provider
- The spouse of the waiver participant

Section VI

What is the intended work schedule of the prospective employee?: Hours per day/days of the week etc. _____

NOTE: If the intended work schedule is more than 40hrs per week please fill out Part C of this form.

Is there staff currently assigned to deliver services to the waiver participant? If so, how many and what hours do they work?

What is the plan to introduce additional staff to provide some of the services that are needed by the waiver participant? _____

Section V – Signatures

- The prospective employee understands that the Provider Agency/Employer of Record will monitor the service that a relative or legal guardian provides each month on-site, at a minimum of one time per month.

- The prospective employee understands that the PBH Support Coordinator will monitor the relative/legal guardian's provision of services on-site, at a minimum of one time per month.

- The prospective employee will provide Community Networking, Day supports, Personal Care, In-Home Skill Building (Individual), In-Home Skill Building (Group), Intensive In-Home Supports, and/or Residential Supports. Payments are only made for service authorized by the PBH Utilization Management Department in the Individual Support Plan.

Signature below certifies that I/we have received and read PBH's Innovations waiver Employment of Relative/Legally Responsible Person policy and that all information on the form is true and accurate. Falsification of this information could result in a Medicaid payback. The employee understands that communications regarding this submission should be directed to their Employer of Record or Provider Agency.

Provider Agency Qualified Professional, Employers of Record, Managing Employers
Signature, Title and Date

Employee Providing Service Signature, Relationship and Date

NOTE: If this form is incomplete it will be denied

Optional Comments: _____

Forward Information to: PBH Network Department