



**VERIFICATION OF  
RELATIVE/LEGAL GUARDIAN AS DIRECT SUPPORT EMPLOYEE**  
This document is to be completed by PBH Network Provider Agency 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 B Application – Existing Employees**

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

**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 the 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 answer the following:

Year and month that the relative/legal guardian was hired by your agency: \_\_\_\_\_  
Did the relative/legal guardian work for another provider agency prior to employment with your agency?  Yes  No. If yes, which agency? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your agency employ other staff to provide services to this waiver participant?   
Yes  No. If yes, what other services? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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.)

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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? \_\_\_\_\_

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**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? \_\_\_\_\_

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

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**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