

Self-Direction Employer Attestation Form

October 2023

Explains responsibilities in Self-Direction and requires the following information:

Section 1


- **Authorized Representative Name**
- **Beneficiary Name and Medicaid ID #**
- **Address (Shared or Not Shared)**



Section 2

- **Fiscal Employer Agent (FEA) Vendor Name**
- **Medicaid Provider ID**
- **FEA Vendor Rep Name**



 LOUISIANA DEPARTMENT OF HEALTH <small>Office for Citizens with Developmental Disabilities</small>	SELF-DIRECTION EMPLOYER ATTESTATION FORM
Self-Direction Employer Attestation Form	
<p>Self-direction is a service delivery which allows beneficiaries or their Authorized Representative to become the employer of the Direct Support Professionals (DSPs) they choose to hire to provide their supports. As the employer, the beneficiary or their authorized representative is responsible for recruiting, training, supervising and managing their DSPs.</p> <p>The Authorized Representative/Employer has certain responsibilities for their role in the beneficiary's Self Direction Program and these responsibilities must be fulfilled by the person signing below. (The Authorized Representative/Employer must be 21 years of age or older.) The responsibilities below remain the same whether or not the employer/authorized representative lives in the home with the beneficiary or not. Under no circumstances should a person sign as the employer if they do not intend to carry out ALL of the responsibilities listed below as they will be held liable if the beneficiary is harmed in the Self-Direction program or if fraud is committed.</p>	
Authorized Representative/Beneficiary Information	
Authorized Representative Name:	
Beneficiary Name:	
Beneficiary Medicaid ID#:	
Shared Address:	
Address if not Shared:	
Fiscal Employer Agent Vendor Information	
Fiscal Employer Agent Vendor Name:	
Medicaid Provider ID:	
Fiscal Employer Agent Vendor Representative Name:	
Self-Direction Attestation Form OCDD-RF-23-001	

Enter the waiver beneficiary's name on the first line.

Self-Direction Employers should read and initial each statement for the requirements listed.



**SELF-DIRECTION EMPLOYER
ATTESTATION FORM**

As the Self-Direction Employer for _____, I am attesting to all of the following (must initial by each section):

_____ I declare that I am at least 21 years of age, live in Louisiana and in close proximity to the participant to be able to carry out all responsibilities.

_____ I understand I must adhere to the health and welfare safeguards identified by the team (the beneficiary, the Support Coordinator, family, any professionals involved and anyone the beneficiary wants involved in their life), including the application of a comprehensive monitoring strategy and risk assessment.

_____ I understand all services must be documented in service notes, which describes the services rendered and progress towards the beneficiary's personal outcomes in the plan of care. I understand I must see that the Direct Support Professional (DSP) does this for each shift worked.

_____ I understand the Electronic Visit Verification (EVV) system must be used when the DSP starts and ends the established work shift and that if the schedule changes from what is in the Plan of Care daily schedule, it must be documented as to why the change occurred.

_____ I understand the beneficiary's Rights and Responsibilities and I will ensure that these rights are respected.

_____ I understand critical incidents must be reported within 24 hours to the beneficiary's support coordinator/support coordination agency and any emergency room visits and/or hospitalizations must be reported as soon as possible but within the 24-hour period. Some examples of critical incidents are emergency room visits, evacuations, and hospitalizations.

_____ I understand service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home and any hours over this time must not be billed to Medicaid.

_____ I understand services must be provided with the beneficiary present. A DSP cannot leave a beneficiary at home while they run errands nor can they run personal errands while "on the clock" working with the beneficiary.

_____ I understand DSPs cannot work another job at the same time they are caring for the beneficiary and billing Medicaid nor can they care for other children or adults while caring for the beneficiary and billing Medicaid.

_____ I agree to notify the Department of Children and Family Services/Adult Protective Services/Elderly Protective Services or LAW ENFORCEMENT immediately should any form of abuse or neglect occur.

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Age, Location and Responsibilities

- 21 Years of Age
- Live in Louisiana
- Close proximity to participant to carry out responsibilities



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_____ I understand all services must be documented in service notes, which describes the

Health and Welfare Safeguards

- There is a team of individuals who help create a plan of care for the beneficiary that identifies the person support needs. The plan of care also identifies “risk factors” the waiver beneficiary may have and supports needed to mitigate these risks.
- A direct support professional (DSP) must follow any health and welfare safeguards the plan of care team has identified.
- As the employer, you are required to make sure the DSPs are ensuring the health and welfare of the individual.



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_____ I understand all services must be documented in service notes, which describes the services rendered and progress towards the beneficiary’s personal outcomes in the plan of care. I understand I must see that the Direct Support Professional (DSP) does this for each shift worked.

Plan of Care and Documentation

- The DSP must follow the plan of care that is developed for the beneficiary with the plan of care team.
- The DSP must keep documentation (notes) of what was done throughout the day to help meet the plan of care goals.
 - ❖ Notes should be meaningful and describe what was done throughout the day.
 - ❖ Notes can't just say "today was great," they should give details of what was done and how it helps meet plan of care goals.
- As the employer, you have to review the notes, and keep a record of the notes.

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_____ I understand the Electronic Visit Verification (EVV) system must be used when the DSP starts and ends the established work shift and that if the schedule changes from what is in the Plan of Care daily schedule, it must be documented as to why the change occurred.

_____ I understand the beneficiary's Rights and Responsibilities and I will ensure that these rights are respected.

Electronic Visit Verification

- EVV must be used when the DSP starts and ends the established work shift.
- If the schedule changes from what is in the Plan of Care daily schedule, it must be documented as to why the change occurred.
- As the employer, you must ensure that your employees use this system.

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Beneficiary's Rights and Responsibilities

- Waiver beneficiaries have Rights and Responsibilities associated with receiving these services.
- As the employer, you must ensure that these rights are respected.

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_____ I understand critical incidents must be reported within 24 hours to the beneficiary's support coordinator/support coordination agency and any emergency room visits and/or hospitalizations must be reported as soon as possible but within the 24-hour period. Some examples of critical incidents are emergency room visits, evacuations, and hospitalizations.

Critical Incidents

- **Must report** critical incidents to support coordinator agency within 24 hours of the incident.
- Critical incident categories include:
 - ❖ Abuse, neglect, including self-neglect, or exploitation
 - ❖ Death
 - ❖ Extortion
 - ❖ Falls
 - ❖ Involvement with law enforcement
 - ❖ Loss or Destruction of Home
 - ❖ Major behavioral incident (Suicide threat, Missing person, Self-Injury, Nonconsensual sexual behavior, physical aggression)
 - ❖ Major Illness/Injury: Urgent care, acute care, or emergency room
 - *Bowel obstruction, decubitus, pneumonia, seizure*
 - ❖ Major medication incident
 - ❖ [Restraint use](#)
- You can read the [OCDD Critical Incident Operational Instruction \(OI F-5\)](#) at the OCDD Website.

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_____ I understand service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home and any hours over this time must not be billed to Medicaid.

_____ I understand services must be provided with the beneficiary present. A DSP cannot leave a beneficiary at home while they run errands nor can they run personal errands while "on the clock" working with the beneficiary.

40 Hours a week

- Anyone who is working for the beneficiary **and living in the home with the individual** cannot be paid for working more than 40 hours in a week (Sunday to Saturday)
- For example, if mom and sister both work for the individual, and the individual is getting 24 hours care:
 - ❖ Mom can be paid for up to 40 hours per week (Sunday to Saturday)
 - ❖ Sister can be paid for up to 40 hours per week (Sunday to Saturday)

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I agree to notify the Department of Children and Family Services/Adult Protective Services/Elderly Protective Services or LAW ENFORCEMENT immediately

On the Clock

- A DSP cannot do personal errands while working for the beneficiary.
 - ❖ If out in the community that trip must be for the benefit of the beneficiary.
 - ❖ A DSP can't go to the store to pick up their own items, or run to the post office while on the clock—even if they take the individual with them.

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Form 10015-01-2019, Department of Children and Family Services (MCH)

Working Another Job

- A DSP cannot work another job while being paid to care for a beneficiary. That means they cannot:
 - ❖ Run an Etsy shop while on the clock
 - ❖ Sell things on eBay while on the clock
 - ❖ Work from home on another job while on the clock

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_____ I understand DSPs cannot work another job at the same time they are caring for the beneficiary and billing Medicaid nor can they care for other children or adults while caring for the beneficiary and billing Medicaid.

_____ I agree to notify the Department of Children and Family Services/Adult Protective Services/Elderly Protective Services or LAW ENFORCEMENT immediately should any form of abuse or neglect occur.

Reporting Abuse / Neglect / Exploitation / Extortion

- Life Threatening Situation – dial 911
- Child Protection Services (Age 0 – 17)
 - 1-855-452-5437
- Adult Protective Services (Age 18 – 59)
 - 1-800-898-4910
- Elderly Protective Services (Age 60+)
 - 1-833-577-6532

beneficiary and billing Medicaid nor can they care for other children or adults while caring for the beneficiary and billing Medicaid.

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Self-Direction Employer's Handbook

- Read the most up to date handbook to understand provisions.
- Ask questions if there's something you don't understand.



SELF-DIRECTION EMPLOYER ATTESTATION FORM

_____ I understand I am to read the most up to date Self-Direction employer's handbook and to understand the provisions in it. If there is something I don't understand I am to ask questions until I do understand.

_____ I understand that, as an employer, my DSPs should not be asked to do any activities that are not directly for the beneficiary, on the plan of care and should not be subjected to harassment in any form, verbal, sexual or other. If problems occur, it is my job to address them immediately.

_____ I understand that I am responsible for reviewing each payroll report to make sure

DSP Activities

- DSPs cannot be asked to do any activities that are not directly for the beneficiary or the plan of care.
- DSPs should not be subjected to verbal, sexual or other harassment.
- If problems occur, address them immediately.



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_____ I understand that, as an employer, my DSPs should not be asked to do any activities that are not directly for the beneficiary, on the plan of care and should not be subjected to harassment in any form, verbal, sexual or other. If problems occur, it is my job to address them immediately.

_____ I understand that I am responsible for reviewing each payroll report to make sure employees are being paid the correct rate for the correct number of hours worked, and there is enough hours in the account to continue receiving paid services for the remainder of the coordinator. I understand I should contact the Fiscal Employer Agent if I do not receive payroll reports.

Payroll Reports and Time Worked

- You are responsible for reviewing payroll reports to ensure employees are paid the correct rate for the correct number of hours worked.
- Contact the Fiscal Employer Agent if you do not receive payroll reports.
- You are also responsible for approving all time worked by each DSP.

are not directly for the beneficiary, on the plan of care and should not be subjected to harassment in any form, verbal, sexual or other. If problems occur, it is my job to address them immediately.

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_____ I understand that I am responsible for approving all time worked by each DSP and that all activities delivered by the DSP meet the requirements outlined in this attestation form.

_____ I understand that I must ensure employee background checks and required screenings are conducted prior to the employee working and at intervals as required in Appendix H of the OCDD Self-Direction Handbook.

Background Checks

- Background checks and screening of employees and employers will be initially conducted by the Fiscal Employer Agent.
- You must check two sites on a monthly basis to ensure that your employees are not on this list:
 - Louisiana State Adverse Actions List: <https://adverseactions.ldh.la.gov/SelSearch>
 - Office of Inspector General (OIG) List of Excluded Individuals:
 - <https://exclusions.oig.hhs.gov/>
 - If employee is added to list, they must be terminated.

reports.

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_____ I understand that if all rules and regulations of the Self-Direction waiver option are not followed, the beneficiary may be asked to leave Self-Direction and choose a provider agency.

_____ I understand that the HCBS Waiver program is funded by State and Federal dollars and at *any time without advanced notice* I may be asked to turn over DSP notes and/or records to the OCDD Monitoring Unit, Louisiana Department of Health's Program Integrity, the

Rules and Regulations

- All rules and regulations of the Self-Direction waiver option must be followed.
- If not, the beneficiary may be asked to leave Self-Direction and choose a provider agency.

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_____ I understand that if all rules and regulations of the Self-Direction waiver option are not followed, the beneficiary may be asked to leave Self-Direction and choose a provider agency.

_____ I understand that the HCBS Waiver program is funded by State and Federal dollars and at *any time without advanced notice* I may be asked to turn over DSP notes and/or records to the OCDD Monitoring Unit, Louisiana Department of Health's Program Integrity, the Louisiana Legislative Auditor, the United States Department of Justice, and/or the United States Office of the Inspector General's Office.

Recordkeeping

- As the employer it is your responsibility for keeping records including (but not limited to payroll records and DSP progress notes.)
- HCBS waivers are funded by state and federal dollars, so you may be asked to turn over DSP notes and/or records to the OCDD Monitoring Unit, LDH and other entities.
- You may be required to turn over those documents with no notice to OCDD, Louisiana Department of Health Program Integrity, the Legislative Auditor, the Department of Justice, or the Office of the Inspector General.
- You should keep your records for at least six years.

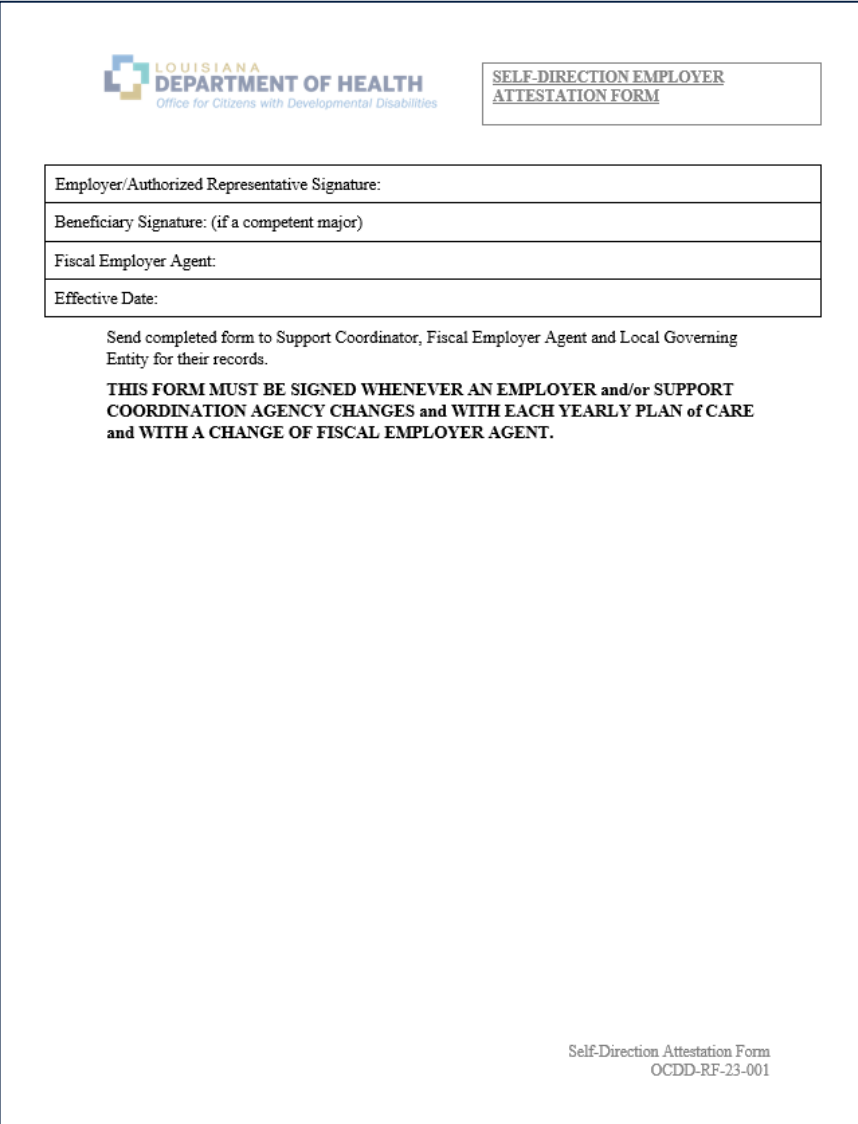
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Signing this document is an attestation that, to the best of my knowledge, the information on this form is true and accurate and I understand the responsibilities of working under the HCBS waiver program. I understand that falsifying or omitting information may result in an investigation by Medicaid Program Integrity and/or the Louisiana Attorney General's Office or any other state or federal agency with oversight of home and community based services and/or Medicaid funds resulting in jail time and/or a recoupment of paid claims.

The following must sign and date:

- Employer/Authorized Rep
- Beneficiary
- Fiscal Employer Agent



 **LOUISIANA
DEPARTMENT OF HEALTH**
Office for Citizens with Developmental Disabilities

**SELF-DIRECTION EMPLOYER
ATTESTATION FORM**

Employer/Authorized Representative Signature:
Beneficiary Signature: (if a competent major)
Fiscal Employer Agent:
Effective Date:

Send completed form to Support Coordinator, Fiscal Employer Agent and Local Governing Entity for their records.

THIS FORM MUST BE SIGNED WHENEVER AN EMPLOYER and/or SUPPORT COORDINATION AGENCY CHANGES and WITH EACH YEARLY PLAN of CARE and WITH A CHANGE OF FISCAL EMPLOYER AGENT.

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OCDD-RF-23-001

THANK YOU

