

Employer Instructions for Self-Direction Attestation

1. All OCDD Self-Direction employers must complete the [Self-Direction Attestation Form](#) as soon as possible but **no later than December 31, 2023**, even if you are not changing anything about your current situation. Remember that **after November 11, 2023**, the employer and the employee cannot be the same person.
2. Employers must read all four pages of the memo numbered *OCDD-R-23-005* (linked [here](#)).
3. Employers should watch the **Self-Direction Employer Attestation video** (click the [second link on this page](#)) while completing the attestation form. This step must not be skipped, and it is very important that the employer watch it. The video goes over the form blank by blank, step by step, page by page.
4. The employer must complete and return this [attestation form](#) as soon as possible. If not completed and returned by **December 31, 2023**, the employer (and/or beneficiary) **will be removed from the Self-Direction option** and offered a choice of waiver providers through a collaborative process involving the Support Coordinator (SC) and Fiscal Employer Agent (FEA).
5. By signing as the employer, you are agreeing to do all these activities on behalf of the beneficiary. These activities are not assignable to another person.
6. The employer **must also initial all the blanks of the required activities** you will be responsible for completing on **pages 2 through 3**. If there are any activities you are not comfortable doing, you cannot be the employer.
7. As the employer you must understand all of the requirements and that there is **no Medicaid reimbursement for the employer**. Once this is understood, go to **number 9**.
8. The employer must **sign page 4, have the beneficiary sign** and the employer must **return the attestation form to the FEA**. The FEA will **assign a start date** for you to become the employer.
9. Please send any questions to Selfdirection@la.gov.

**Family/Legally Responsible Individual (LRI) as Paid Caregiver (Employee) in the Self-Direction Program Attestation Form (Self-Direction Instructions)
(Same Attestation form as the HCBS Service Provider Form)**

1. All family members living in the home and working as Direct Support Professionals (DSPs)/Self-Direction employees must sign an attestation form.
2. Family working as Self-Direction Employees (DSPs) and living in the same home or LRIs must sign this form as soon as possible but no later than December 31, 2023.
3. Prior to a family member becoming or remaining a Self-Direction Employee (DSP), the Support Coordinator (SC) will discuss the best interest, self-determination and extraordinary care with the beneficiary or legal guardian depending on the age of the beneficiary.
4. Both provider agencies and Self-Direction Employers must let the SC know that a family member is a paid worker and wishes to remain a paid worker in all situations. This will allow the SC to complete their portion of the process.
5. Best interest: SCA is responsible for determining if family as paid caregiver is in best interest of individual.
6. Self-Determination: The SC must ensure the individual understands person choice and self-determination.
7. Extraordinary Care: In Louisiana, a legally responsible individual (LRI) is: parent of a minor child, spouse, or curator/continued tutor for an adult. A LRI can ONLY serve as paid staff when extraordinary care is needed. To establish Extraordinary Care the following must be considered:
 - Availability of other qualified support staff;
 - Type of support/care needed compared to what would typically be expected for a LRI; and
 - Expectations of some support/interaction/relationship with LRI that is NOT paid.
8. If there are any concerns/issues about the family member/LRI working with the beneficiary, the SC will contact the Local Governing Entity (LGE) for guidance.

9. Once Best Interest and Extraordinary Care (if applicable) is determined that the family member or LRI is going to be a Self-Direction Employee (DSP), and this is in the best interest of the beneficiary, the SC signs the (Self-Direction) Family/Legally Responsible Individual (LRI) as Paid Caregiver Attestation Form and sends it to the HCBS Service Provider. The SC signs that the above conversation was held, the process followed with the ID team for the beneficiary, and that the DSP(s) are the best fit for the beneficiary.
10. **IT IS THE RESPONSIBILITY OF THE SELF-DIRECTION EMPLOYER** to share the video and attestation linked here: <https://www.ldh.la.gov/news/7169> with family members living in the home and LRI living in the home or not and serving as paid staff (DSPs).
11. Potential or Current DSPs (family members/LRI) should watch the instruction video as they complete the attestation form.
12. Potential or Current Self-Direction Employees (DSP family members/LRI) should initial all the blanks on pages 2 and 3 indicating understanding of what is expected of them and the do's and don'ts of being a DSP while also a Self-Direction Employee (DSP/LRI).
13. If there is anything or any one of the items that you, as a Self-Direction Employee (DSP and family member/LRI) do not understand, you should ask the SC or Self-Direction Employer to explain it to you before you initial and sign the document. You are signing indicating that you understand official Federal rules of the Centers for Medicare and Medicaid and assurances that the state of Louisiana has given them concerning the waiver program that the beneficiary receives.
14. The potential or current Self-Direction Employee (DSP/family member/LRI) should sign on the last page of the attestation form indicating understanding of the rules of the program.
15. NOTE: All Self-Direction Employees who are also family members and are living in the home and working as DSPs for the beneficiary must complete an attestation form. All legally responsible individuals working as a Self-Direction Employee (DSP) must also complete an attestation form whether they live in the home or elsewhere.
16. After the Self-Direction Employee (DSP) has signed the form, the Self-Direction Employer should sign the form on the last page and return it to the SC.
17. Upon receipt of the attestation form, the SC will review the form to ensure that all sections are complete, ensure that all family members/LRI working as Self-Direction Employees (DSPs) have completed an attestation form, and then sign on the last page and indicate an effective date for the family member/LRI to begin employment (this may require collaboration with the Fiscal Employer Agent, the Self-Direction Employer and the potential Self-Direction Employee (DSP)).

NOTE: Background checks are required for Self-Direction Employee family members. (Office of Inspector General (OIG) Exclusions checks are required for Employers.)

18. Once the effective start date is established the SC should share the form with the following entities:

The Local Governing Entity
The Self-Direction Employer
The Fiscal Employer Agent
The Support Coordination Agency Beneficiary File
LDH Data Contractor (Statistical Resources)

A Note on the Authorized Representative/Employer:

- A person who agrees to be an authorized representative for the purpose of the plan-of-care can still be a DSP.
- A person who agrees to assist with the Medicaid application can still be a DSP.

“I understand that the function of the Authorized Representative is to accompany, assist, and represent me in the waiver evaluation process, and to aid in obtaining all necessary documentation for the agency’s evaluation for Home and Community-Based waiver services. I also understand that my Authorized Representative has the power to make decisions for me concerning all aspects of various waiver programs administered by the Louisiana Department of Health (LDH).”

This would also be part of the employer’s responsibilities.

SELF-DIRECTION EMPLOYER
ATTESTATION FORM

Self-direction is a service delivery which allows beneficiaries or their Authorized Representative to become the employer of the direct service professionals 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 direct service professionals.

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.**

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:

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 understand DSPs may not give any medications or complete complex medical tasks for a waiver beneficiary unless the medication or non-complex task is one that is able to be delegated.

_____ I agree to notify DCFS/APS/EPS or LAW ENFORCEMENT immediately should any form of abuse or neglect occur.

_____ 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 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.

_____ 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.

_____ 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.**

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.

SELF-DIRECTION EMPLOYER
ATTESTATION FORM

Employer/Authorized Representative Signature:	Date:
Beneficiary Signature (if a competent major):	Date:
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.