ALL SAINTS HOME CARE, INC.

Dear Client,

We would like to welcome you to our FMS agency and to thank you for choosing All Saints Home Care as your payroll agent.

Enclosed in this folder you will find the paperwork needed to begin your services. One side of the folder is the paperwork you, the client, will need to complete and the other side is what your chosen caregiver will need to complete. Both packets need to be filled out and signed/dated where indicated and returned to All Saints Home Care in the enclosed self-marked envelope in the folder before the start of services. We encourage you to review the employee materials so you are familiar with their requirements.

All Saints Home Care participates in the state mandated time keeping IVR (interactive voice response) program called Authenticare. Once we receive yours and your caregiver's information, we will enter that information into the Authenticare system. Then we will mail your workers ID number and service codes as well as an instruction sheet and policy on how to use the IVR system. This is how they clock in and out for the hours they work and report what care activities they performed. We highly recommend that you have your worker also write the times they arrived and left on a calendar for your records and to ensure Plan of Care compliance.

Enclosed in your packet is also an educational handout about some of the state requirements for self-directing your care. Please review this information with your worker at the start of your services. Also enclosed is information regarding client obligation requirements. All Saints has a strict compliance policy regarding collection of client obligations.

Additional information and policies regarding waiver services may be found on our website at www.allsaintshomecare.com. Please like us on FaceBook to stay updated on various healthcare topics and events, as well as company updates, promotions and office closings.

We look forward to working with you and ask that if you have any questions that you contact us at your earliest convenience at 316-755-1076 for assistance.

Sincerely,

Daron Kasselman
CEO

ALL SAINTS HOME CARE, INC.

# Checklist of items to be signed and returned:

**CLIENT**

FMS Client Profile

- ☐ Medication list
- ☐ Client Authorization for Consumer Directed Attendant Care
- ☐ FMS Agent Responsibilities
- ☐ Client Responsibilities
- ☐ Release from Liability
- ☐ Insurance Information
- ☐ Authorization use of fax
- ☐ Consent to care
- ☐ Customer & Provider Agreement
- ☐ Patient information on Advanced Directives
- ☐ Grievances
- ☐ Client Rights and Responsibilities

**Review with your Caregiver the following**

- ☐ Initial Service and Hours Worksheet
- ☐ Expected Activities Worksheet
- ☐ Authenticare Policy
- ☐ Kancare Expectations

*Please note that your services will not be able to start and your worker will not be able to be compensated until all the above forms are completed, signed, and dated and received in the office. Please allow 48 hours for processing. If corrections are needed or forms are missing the processing time will be extended.*

**Caregiver**

- ☐ FMS Employee Application
- ☐ Signature Page – please sign and date all lines
- ☐ FMS Direct Support Worker and Provider Agreement
- ☐ Employment Service Agreement
- ☐ Direct deposit form (if desired)
- ☐ I-9 (Will need Photo ID and other form of Identification-see form)
- ☐ W-4
- ☐ K-4

*Again please note that no pay can be issued until all of the above forms are completed, returned, are correct, and are verified and processed by the office. Please allow 48 hours for processing. If corrections are needed this will lengthen the processing time.*

# PLEASE COMPLETE & RETURN THE FOLLOWING FORMS.

PLEASE NOTE THAT THESE FORMS MUST BE RETURNED TO THE FMS AGENT BEFORE ANY SELF-DIRECT EMPLOYEES CAN BE PAID.

ALL SAINTS HOME CARE, INC.

**FMS Client Profile**

Office Use Only:
Date Received: _____

S.O.C. Date:_____

_____
Name

_____
Address

_____
City State Zip

_____ _____
Home Phone Cell Phone

Email: _____

Social Security #: _____-_____-_____

Medicaid Number: _____

Date of Birth:_____/_____/_____ Sex: Male ( ) Female ( )

Race: _____

Physician: _____ Phone:_____

Physician Address: _____

_____

Primary Language spoken:_____

Diagnosis/Illness/Disabilities:_____

_____

Allergies: _____

Nearest Relative:_____
Name Number

Emergency Contact: _____
Name Number

ALL SAINTS HOME CARE, INC.

Client Signature:_____ Date:_____

CLIENT MEDICATION RECORD

Client: _____ Doctor:_____ Phone_____

Address:_____ Pharmacy_____Phone_____

_____ Emergency Contact _____

Phone_____ Relationship_____Phone_____

Allergies: _____

| *Start* | *DC* | *Medication* | *Amount* | *Route* | *Frequency* | *Reason* |
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Comments:

_____

_____

Client Signature: _____Date: _____

**FMS Agenct Responsibilities**

- The FMS Agent will be responsible to obtain consents for management support from the client.
- The FMS agent will be responsible to provide time records to caregivers.
- The FMS Agent will be responsible to manage all payment issues (withholding, W2 at year end, FICA, Workers Compensation and Unemployment insurance).
- The FMS agent will be responsible to perform background checks on all Self Direct workers.
- The FMS Agent will be responsible to offer all clients discrete screening of chosen employees for the following:

(**Please indicate by check marking which of these items you would like the FMS Agent to obtain on your chosen employee. If none please only sign/date below and return the form.)**

1. Drug Screening []
2. TB Testing []
3. Medical Inquiry []
4. Blood borne Pathogens Training []

Client Signature Date

FMS Agent Representative Date

## Client Responsibilities

- The client will be responsible to advertise for or otherwise recruit applicants/employees.
- The client will be responsible to screen and interview for appropriateness of employees.
- The client will be responsible to instruct the attendant on employee conditions and the requirements of the plan of care issued by the insurance company.
- The client will be responsible to explain the payment process and the required approval of their time record to their attendant/employee
- The client will be responsible to sign the time sheets or verify IVR (integrated voice response) time claims for each employee that works hours as indicated in the Plan of Care as approved by your Case Manager.
- The client will be responsible to direct the attendants to the FMS Agent for completion of the employment process.
- The client will be responsible to arrange for back up staff in the event of sickness or time off by your employee/s.
- The client will be responsible to ensure that employees do not begin work until cleared and authorized by the FMS Agent.

Client signature:_____ Date:_____

FMS Agent Representative: _____ Date: _____

ALL SAINTS HOME CARE, INC.

**Client Authorization for Consumer Directed Attendant Care**
**Release from Liability**

I acknowledge and release the FMS Agent for liability for the following items:

- Collecting application information
- Interviewing
- Selection of care attendants
- Training of care attendants
- Assigning work hours
- Maintaining time records
- Forwarding time records to the FMS Agent
- Monitoring performance of care attendants
- Dismissing caregivers
- Recruitment of backup replacement attendants

In the event that problems arise which I feel are beyond my experience or ability to manage, I must inform the FMS Agent to enlist their aid. Should the FMS Agent representative see the situation as dangerous or fraudulent or urgent in some other way, they may intervene to end the Personal Care Attendants services or make a report to the appropriate outside agencies, which could include, but not limited to the Medicaid Fraud Hotline, Adult Protective Services, the Client's Case Manager and insurance company, Kansas State Departments of Aging and Disabilities Services and Dept. of Child and Family Services, local law enforcement agencies and the FMS Agent's legal representation.

If All Saints Home Care, Inc. has no knowledge of problems with the Care Attendant I have chosen, and am managing, I absolve the FMS Agent of liability for harm to my household or me.

Urgent items to notify the FMS Agent would include but not be limited to:

- Care attendant performance problems, which result in the client's needs being unmet
- Client not allowing normal performance of services
- Personal Care Attendant having a current drug abuse problem
- Personal Care Attendant having a felony history associated with violence or dishonesty

Please note a Personal Care Attendant will be terminated per the Medicaid & KDAD guidelines if an investigation or background report notifies the FMS Agent of ineligibility to work as a Personal Care Attendant for any reason.

Client:_____ Date:_____

FMS Agent Representative:_____ Date:_____

ALL SAINTS HOME CARE, INC.

**Insurance Information**

Name: _____

Medicaid Number: _____

Medicare Number: _____

**Secondary or Long Term Care Insurance (If not applicable, Mark N/A)**

Insurance Type: _____

Policy Holder Name:_____

Policy Number: _____

Plan Number: _____

Plan Name: _____

Policyholder Relationship to Customer: _____

**Consent and Notifications:**

In order to properly bill your insurance and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes, you will be required to submit the new information.

**Acknowledgement:**

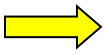
I have read and understand the above statement and agree to all provision and outlined herein.

**Consent:**
I hereby give my consent to the provide(s) listed above to bill my insurance and/or Medicaid for services rendered.

_____ _____
Signature of Individual or Responsible Party Date

## Authorization Use of Fax

My signature below indicates that I authorize the use of electronic fax as a documentation of care log timesheet. If the original timesheet is lost or misplaced,
the fax copy is authorized to replace the original timesheet.



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Client Signature Date

ALL SAINTS HOME CARE, INC.

# CLIENT CONTRACT

Name_____ D.O.B._____

SS#_____/_____/_____ Medicaid #_____

## CONSENT TO CARE

I consent to Financial Management Service as provided by All Saints Home Care, Inc.

## RELEASE OF INFORMATION

I authorize All Saints Home Care, Inc. to obtain care records from any health care institution, insurance company, or physician that apply to my care needs within the FMS Agent. I authorize release of all FMS Agent records to the payer for review, as the payer requires.

## FINANCIAL RESPONSIBILITY

I understand and agree that I am responsible for the following financial obligation:

Client Obligation: $_____

I understand that if my client obligation changes at any time that I will be billed accordingly including any retroactive changes without any advanced notice.

I understand that if I fail to pay the Client Obligation that All Saints Home Care reserves the right to discontinue my services for non-payment after notifying me and my Insurance Case Manager.

## PAYMENT AUTHORIZATION

I authorize payment for services directly to All Saints Home Care, Inc. when a third party Reimburses for my care. I authorize All Saints Home Care, Inc. to act as my representative concerning my claim or asserted right under Medicaid or county funded programs.

## ACKNOWLEDGEMENT OF WRITTEN MATERIAL

This form has been thoroughly explained to me and I certify that I understand its contents. The FMS Agent has informed me of my PATIENTS RIGHTS AND RESPONSIBILITIES, GRIEVANCE POLICY, ADVANCE DIRECTIVES, AND THE NUMBER TO CONTACT THE STATE HOME HEALTH HOTLINE. Copies of all these forms have been provided to me.

Client Signature_____ Date_____

FMS Agent Representative_____ Date_____

# GRIEVANCES

Any client who feels his/her rights have been denied should contact the FMS Agent's Client Care Manager either verbally or in writing (within 30 days). Direct all complaints and questions to the main office at (316) 755-1076

1. The FMS Agent Client Care Manager shall make every effort to investigate and resolve the complaint within 15 days from the date of notification and notify the client of the results of the investigation.

2. If the FMS Agent's Client Care Manger has not resolved the complaint, a written complaint should be submitted to the FMS Agent's Administrator.

3. The FMS Agent's Administrator shall take whatever steps are necessary to resolve the complaint and notify the client of the resolution within 30 days of the date of notification.

4. The client shall be advised of the availability of the state's toll-free home health FMS Agent hot line, including the telephone number (present on the Client's Bill of Rights and below), its hours of operation, and its purpose, which is to receive complaints or questions about local Home Health Agencies.

| **All Saints Home Care**<br>**Monday - Friday 8-5**<br>**(316) 755-1076** |
|---|

| **State Home Health Complaint Line**<br>**Monday - Friday 8 - 5**<br>**1-800-842-0078** |
|---|

Client Signature_____ Date_____

FMS Agent Representative_____ Date_____

# Patient Information on Advanced Directives

All adults receiving home care have certain rights guaranteed by law. These rights include the following:

**1.** You have the right to know in advance what medical care you will be receiving from your home health care provider.

**2.** You have the right to accept or refuse medical or surgical treatment; and

**3.** You have the right to prepare legal documents known as Advanced Directives.

Advanced Directives include two types of legal documents:

**A**.) A Living Will & **B.)** A Durable Power of Attorney for Health Care.

**A Living Will**- is a legal document that allows you to express your wishes regarding life-sustaining treatment when your condition is terminal and when treatment would merely prolong death. If you prepare a Living Will it will mean that if your attending physician and one additional physician have determined that you will die whether or not life-sustaining procedures are utilized and that application of life-sustaining procedures would only serve to artificially prolong the dying process, that such procedures will not be used. Your wishes as expressed in a Living Will, will only be followed if you are unable for any reason to communicate your wishes yourself (such as if you are unconscious or in a coma). You may, if you wish, cancel and revoke a Living Will at any time by destroying it, by preparing a written revocation, or by verbally revoking it.

A Living Will is a very important legal document. Before preparing a Living Will you may want to discuss it with your family, a close friend, your doctor, and/or a lawyer. If you decide you want to prepare a Living Will, you may contact the office for assistance in obtaining forms or call your attorney for further assistance. The FMS Agent policy is to honor your wishes as expressed by you in your Living Will.

**A Durable Power of Attorney for Health Care**- is a legal document used to appoint another person as your personal representative, or agent, to make health care decisions for you when you cannot make those decisions yourself. This person can accept or refuse treatment for you on your behalf, if you choose to have Durable Power of Attorney for Health Care Decisions, you should name an agent who knows your values and goals relating to treatment and whom you trust to carry out your wishes. This agent does not have to be a family member, but you may choose a family member to be your agent if you like. Talk with your agent about your wishes and confirm that he or she is willing to act on your behalf. Writing a statement that the document is revoked can revoke a Durable Power of Attorney for Health Care. This statement of revocation must be witnessed or notarized.

A Durable Power of Attorney for health care is a very important legal document. If you wish to have one please express this and we will provide you with a form or again you may contact your attorney. The FMS Agent policy is to honor your wishes as expressed by you in your Durable Power of Attorney for Health Care.

In deciding whether to prepare advance directives, you may wish to consult with your doctor. Your doctor can discuss with you your general health, the general prospect for future illnesses, and a range of treatments. Your doctor can also educate you regarding the specific nature of various treatments. This will enable you to decide whether you would want a particular type of treatment or not. You may also want to talk with an attorney since Advance Directives are legal documents that can have very important legal consequences.

If you decide to prepare Advance directives or appoint a Durable Power of Attorney for Health Care be sure your physician, family member, friend, agent, and/or attorney, as well as the home care FMS Agent have copies on file to comply with your wishes.

**IMPLEMENTING YOUR RIGHTS**

1. Our FMS Agent will be glad to assist you and provide additional resources for more information.
2. Our FMS Agent will not discriminate against you regardless of your decisions regarding your health care.
3. Our FMS Agent will maintain records as to whether or not you have chosen to execute Advance Directives.
4. Our FMS Agent will comply with all current and any new laws regarding Advance Directives.

**PLEASE CONTACT THE DIRECTOR OF NURSING AT (316) 755-1076 TO RECEIVE MORE INFORMATION REGARDING ADVANCE DIRECTIVES**

Client Signature_____ Date_____

FMS Agent Representative_____ Date_____

## CLIENT RIGHTS AND RESPONSIBILITIES

It is expected that the adherence to these rights and responsibilities will lead to better client care and satisfaction for the client and the FMS Agent. The rights will be respected by all FMS Agent staff and used in the home care of the client. A copy of these rights will be given to each new client on admission to FMS Agent and will be displayed in the FMS Agent at all times. All clients have the right:

1. To be free from verbal, physical, mental abuse and exploitation.
2. To have personal property respected as well as protected.
3. To be treated with respect, dignity, and recognition of their individual needs for privacy and care.
4. To quality care that is given without discrimination as to race, color, creed, national origin, age, sex, handicap, or disease process.
5. To be encouraged and/or assisted to exercise rights to grievances, changes in policies, or services, without restraint, interference, coercion, discrimination, or fear of reprisal.
6. To associate or communicate privately with anyone of their choice and to have their mail protected from unauthorized handling.
7. To manage personal finances and receive receipts for purchases made on their behalf and at their request.
8. Assurance that all records, communication, and personal information will be kept confidential. Information will not be released without written authorization from the client or legal spokesperson for the client. Records will be made available upon request.
9. There will be access to personal records upon request unless otherwise indicated by the physician in the clinical record.
10. To choose care providers at will and be assured the FMS Agent will communicate with them.
11. To only be admitted to the FMS Agent for services if the FMS Agent can safely and professionally provide services at the level of need required. Clients have the right to expect reasonable continuity of care.
12. To be informed of the type of service and the amount of service including any monies to be paid by client prior to the start of care.
13. To request information about their diagnosis, prognosis, and treatment, including alternatives and risks of the alternatives, in terms that can be easily understood in order for them to make the best possible decision for consensual care.
14. To be informed orally, and in writing when necessary, of new FMS Agent policies, schedule changes, care plan changes, and any other pertinent changes to their care as soon as the FMS

Agent becomes aware, and before the change occurs.

15. To choose a personal physician.

16. To participate in planning their care and medical treatment with appropriate instruction and education regarding the plan.

17. To refuse treatment after the consequences of refusal have been explained.

18. To be fully aware of the FMS Agent's policies and charges for service, including eligibility for third party reimbursement, prior to receiving care or as soon as eligibility becomes appropriate. Changes which are the responsibility of the client will be clearly explained to the client at the time the FMS Agent becomes aware of the change. The client will be given all information regarding change and others to contact in regards to changes.

19. Not to be transferred or discharged unless medically necessary for the safety and health of others, and in accordance with Medicaid guidelines as referring to non-payment and other issues outlined in service contract.

20. A minimum of 10 days notice prior to transfer or discharge.

21. To be referred elsewhere if the client is denied service for any reason.

22. To exercise his/her rights as a client and in the event the client is unable to exercise his/her rights, the family or legal guardian (providing one has been appointed) may exercise the clients rights on his/her behalf.

| **All Saints Home Care Complaint Line 316-755-1076** | **Kansas Dept. of Aging & Disability Hotline 1-800-842-0078** | **Medical Fraud & Abuse Hotline 1-866-551-6328** |
|---|---|---|

Client Signature_____ Date_____

FMS Agent Representative_____ Date_____

ALL SAINTS HOME CARE, INC.

# FINANCIAL MANAGEMENT SERVICES AGREEMENT

This Financial Management Services Agreement (the **"Agreement"**) is made and entered into this date"_____ by and between All Saints Home Care, Inc. (the **"FMS Provider"**) and _____ (the **"Customer"**)
(Employer/Client's Name)

**WHEREAS,** THE Customer is a participant in a Home and Community Based Services (**"HCBS"**) waiver program under Medicaid (the **"Program**") administered by the Kansas Department of Aging and Disability Services (**"KDADS"**) through KanCare and has elected to self-direct his/her services under the Program by employing one or more direct support workers (each a **"Caregiver"**)

**WHEREAS,** the Customer is the sole employer of his/her Caregiver(s);

**WHEREAS,** the purpose of a Caregiver is to provide assistance and support to the Customer in accordance with the Customer's integrated service plan (the **"ISP"**) under the Program;

**WHEREAS**, as a self-directed participant in the Program, the Customer is required to contract with an entity that has contracted with KDADS to provide financial management services ("**FMS**") under the Program;

**WHEREAS**, the FMS Provider has contracted with KDADS to provide FMS under the Program; and

**WHEREAS**, the Customer desires to retain the FMS Provider to provide FMS, including, but not limited to (i) processing of time worked by the Customer's Caregiver(s), (ii) billing KanCare on the Customer's behalf, (iii) distributing pay checks or electronic deposits for services rendered by each of the Customer's Caregivers under the ISP, (iv) withholding, filing and paying appropriate taxes for Caregiver services under the ISP, and (v) information and assistance services to assist the Customer in understanding his/her role and requirements as the employer of each Caregiver and his/her responsibilities under participant-direction.

**NOW THEREFORE**, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

**Section 1**. **Duties of the Customer**. The Customer's duties under this Agreement include, but are not limited to, the following:

(a) Strictly comply with:
(1) The Customer's ISP, Customer Service Worksheet (if any), and

any and all other Program requirements;

(2) Any and all instructions, rules or policies maintained by the FMS Provider with regard to billing and payment; and

(3) Any and all Kansas statutes, regulations, or policies (including, but not limited to, KDADS's Field Service Manual, as amended from time to time) relating or pertaining to services provided under the Program and for payment for such services;

(b) Choose and direct his/her support services under the Program (e.g., Personal Care Services and Enhanced Care Services);

(c) Understand the roles and responsibilities of the FMS Provider;

(d) Notify the FMS Provider of the Customer's "Designated Representative" (if any), using forms provided by the FMS Provider;

(e) Perform all of the roles and responsibilities as employer of the Caregivers, including, but not limited to, the following:

(1) Recruit, select, interview, hire, train, supervise, and dismiss Caregivers;

(2) Notify the FMS Provider when the Customer desires to hire an individual as a Caregiver, so that the FMS Provider can begin processing the potential hire;

(3) Ensure that all employment paperwork, including Form W-4, Form K-4, and Form I-9, is completed and processed in a timely manner by referring each Caregiver to the FMS Provider as soon as the Customer decides that he/she wants to hire such Caregiver and before such Caregiver begins to work for the Customer;

(4) Negotiate and sign an Employment Agreement with each Caregiver that clearly identifies the responsibilities of the Customer and Caregiver;

(5) In accordance with the ISP, determine the tasks to be performed by Caregiver(s) and where and when they are to be performed;

(6) Manage and supervise the day-to-day HCBS tasks of each Caregiver;

(7) Ensure each Caregiver has resources and training on the use of the AuthentiCare® KS IVR system;

(8) Ensure that the time worked by each Caregiver is delivered according to the ISP;

(9) Approve and validate the time worked by the Caregiver;

(10) Maintain control and oversight of each Caregiver to prevent fraud, waste, abuse and ensure compliance with federal and state rules and regulations;

(11) Ensure each Caregiver is aware of their employment requirements and job responsibilities upon signing the Employment Agreement;

(12) Develop an emergency worker back-up plan in case a substitute Caregiver is ever needed on short notice or as a back-up (short-term replacement Caregiver);

(13) Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by the KanCare Provider Agreement;

(14) Understand and comply with the Program's policies and procedures and federal and state employment laws, including but not limited to the Customer's responsibility to ensure that each Caregiver is paid (a) at least minimum wage for all hours worked, whether or not the hours are approved under the ISP, and (b) overtime wages for all hours over forty that are worked by a Caregiver in a workweek, whether or not the overtime is approved under the ISP;

(15) Provide a safe work environment for the Caregivers;

(16) Provide proper supplies and materials, at the Customer's expense, for each Caregiver to perform his/her duties for the Customer;

(17) As soon as possible but no later than 24 hours after learning of a Caregiver's work-related injury, report such injury to the FMS Provider; and

(18) As soon as possible but no later than 24 hours after learning of the change in status of a Caregiver (including termination of employment, change in contact information, or Form W-4 and Form K-4 elections), notify the FMS Provider of such change in status and provide information to the FMS Provider regarding the change in status, as required in the FMS Provider's sole discretion;

(f) As soon as possible but no later than 24 hours after a change in status of the Customer that would make it impossible for the Customer to receive services under the Program temporarily or permanently (including, but not limited to, loss of the Customer's eligibility for Medicaid, incarceration in a penal institution or admission to an inpatient or residential hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental disease), notify the FMS provider of such change in status; and

(g) Within three working days after a change in contact information for the Customer or his/her Designated Representative (if any) occurs, inform the FMS Provider of such change.

**Section 2. <u>Duties of the FMS Provider</u>**. The duties of the FMS Provider, as agent of the Customer, under this Agreement are as follows:

(a) Comply with the provisions of K.S.A. 39-7,100 and K.S.A. 65-6201;

(b) Comply with all state and federal Medicaid, KanCare, and KDADS requirements;

(c) Support the Customer's right to self-direct his/her in-home support;

(d) Ensure that the Customer, and not the FMS Provider, has the right to choose, direct and control the services and the Caregivers who provide them without excessive restrictions or barriers;

(e) Provide FMS to the Customer, including but not limited to:
  (1) Processing of time worked by Caregiver;
  (2) Billing KanCare on the Customer's behalf;
  (3) Distributing pay checks or electronic deposits for services rendered;
  (4) Withholding, filing and paying appropriate taxes;
  (5) Assisting the Customer in understanding his/her role and requirements as the employer of each Caregiver and his/her responsibilities under participant-direction;
  (6) Assisting the Customer in obtaining a federal employer identification number (FEIN); and
  (7) Arranging for unemployment insurance for the Customer;

(f) Provide human resource documentation and payroll services that support the Customer's role as sole employer of each Caregiver;

(g) As agent of the Customer, conduct background checks on potential Caregivers in accordance with KDADS and other state and federal regulations, review results of background checks, and notify the Customer as to whether a potential Caregiver is eligible for hire based on the results of such background checks;

(h) As agent of the Customer, provide information to Caregivers that outlines the completion of the time-keeping process, wages, and pay days;

(i) Ensure that the Customer, not the FMS Provider, determines the terms and conditions of work (when and how services are provided, such as establishing work schedules, work conditions, and tasks to be performed);

(j) Provide information and assistance services to the Customer, as requested by the Customer;

(k) On behalf of the Customer (who is the sole employer), pay wages to each Caregiver in accordance with state and federal laws; provided, however, under no circumstances will the FMS Provider be obligated to pay a Caregiver for any hours exceeding those allowed on the ISP or by the Program;

(l) On behalf of the Customer (who is the sole employer), maintain all Caregiver records and documentation, as required by KDADS;

(m) On behalf of the Customer (who is the sole employer), arrange for workers' compensation insurance for each Caregiver; and

(n) Upon receiving a report of a Caregiver's workers' compensation injury from the Customer, report such injury to the workers' compensation carrier.

**Section 3. <u>Selection of Caregiver</u>**. The parties agree that the Customer shall have sole discretion whether to hire or continue to employ a particular individual as a Caregiver and that the FMS Provider shall not be involved in such decisions. The Customer understands and agrees that before a Caregiver can begin working:

(a) The Customer must notify the FMS Provider of the Customer's intent to

hire the Caregiver so that applicable processing of the Caregiver (including applicable background checks) can be done by the FMS Provider.

(b) The FMS Provider must have notified the Customer that the results of such background checks qualify the Caregiver to be employed under the Program; and

(c) The Customer and the Caregiver must enter into an Employment Agreement.

The Customer understands and agrees that the Customer, not the FMS Provider, shall be liable for any wages owed to a Caregiver who has not been processed by the FMS Provider and/or who performs work outside the scope of the ISP or Program.

**Section 4. Payment to the FMS Provider**. The parties agree that the FMS Provider shall be paid through the Program for the services that the FMS Provider provides to the Customer under this Agreement. ***The Customer understands that KDADS and/or KanCare will not process payments through the Program without proper documentation from the FMS Provider and/or the Customer and that such documentation must be complete and accurate in order to avoid Medicaid fraud***. Therefore, the Customer agrees to cooperate fully with the FMS Provider to ensure that the FMS Provider is paid through the Program for such services and that the documentation regarding Caregiver services that are provided by the Customer to the FMS Provider is complete and accurate. Furthermore, the Customer understands and agrees that (a) to the extent that the Program requires the Customer to pay a portion of the Caregiver's services ( e.g., a client obligation), the Customer must pay the FMS Provider that amount and (b) if KanCare and/or Medicaid refuses to pay for the services of the Caregiver through the Program, the Customer is personally liable to the FMS Provider for any costs and expenses incurred by the FMS Provider in paying the Caregiver for such services. If the Customer has a monthly client obligation that is assigned to the FMS Provider, the Customer agrees to pay said obligation by the 20th day of each month it is assigned.

**Section 5. Payment for Work Not Covered by ISP or Program**. The FMS Provider has no obligation to compensate a Caregiver for any work for the Customer that is not covered by the Customer's ISP or the Program ("**Non-Covered Duties**"). In the event that a Caregiver performs Non-Covered Duties, the Customer agrees that the Customer is personally liable for compensation owed to the Caregiver for Non-Covered Duties (including any overtime wages attributable to Non-Covered Duties and/or that are not payable under the Program), and the Customer agrees to indemnify, hold harmless, and reimburse the FMS Provider for any payments it makes to the Caregiver for Non-Covered Duties.

**Section 6. FMS Provider is Not the Common Law Employer for Purposes of Patient Protection and Affordable Care Act**. The parties hereby understand and agree that ***the FMS Provider is not the "common law employer" of any Caregiver for***

***purposes of the Patient Protection and Affordable Care Act ("PPACA") or under any other law and that the FMS Provider has no legal obligation to offer health care coverage to any Caregiver***. The parties further agree and understand that, under the legal standards established by the Internal Revenue Service, the "common law employer" for purposes of PPACA compliance is the Customer. The Customer agrees never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "common law employer" of a Caregiver for purposes of PPACA or for any other purpose.

**Section 7. FMS Provider is Not the "Employer" for Purposes of the Fair Labor Standards Act**. The parties hereby understand and agree that ***the FMS Provider is not the "employer" of any Caregiver for purposes of the Fair Labor Standards Act or under any other law that uses the "economic reality test" to determine employer/employee status***. The Customer agrees never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "employer" of a Caregiver for purposes of the Fair Labor Standards Act or for any other purpose.

**Section 8. Medicaid Fraud**. The Customer agrees and understands that if either the Customer or the Caregiver submits false or inaccurate information regarding the work times or duties performed by the Caregiver, it will be considered Medicaid fraud and exploitation of benefits, which the FMS Provider is required to report to the State of Kansas.

**Section 9. Consent to Release Confidential Information**. The Customer consents and authorizes the FMS Provider to release and exchange information related to the services provided by the FMS Provider and any of the Customer's Caregivers (including health information and information that is otherwise confidential) to the following agencies and individuals: the Customer's case manager; the Customer's case management FMS Agent or Case Management Entity ("**CME**") (as applicable); a Managed Care Organization ("**MCO**") involved with the Customer's Program; the Customer's Community Developmental Disability Organization ("**CDDO**"); KDADS; the Division of Health Care Finance of the Kansas Department of Health and Environment; HP Enterprises/KS Medicaid Fiscal Agent; KDADS's Quality Assurance Department; AuthentiCare® KS; third party insurance carriers; and any other governmental FMS Agent as required by law and Kansas FMS requirements.

**Section 10. Coverage by Caregivers**. The Customer understands and agrees that it is the Customer's sole responsibility (not the FMS Provider's responsibility) to ensure that a Caregiver or someone else is present and available to provide services to the Customer and that the FMS Provider is not liable in any way if a Caregiver or another person is not present or available to provide such services.

**Section 11. Liability**. The Customer understands and agrees that the FMS Provider shall not be liable to the Customer for any injuries, claims, losses, expenses, or damages, arising from or in any way relating to the Agreement from any cause or causes including, but not limited to, the negligence, gross negligence, errors, omissions, breach

of contract, or breach of warranty by the FMS Provider, any agent, officer, or employee of the FMS Provider, or any Caregiver, or for the intentional misconduct of any Caregiver. The Customer agrees to hold the FMS Provider harmless from any liability of the FMS Provider to a Caregiver, Medicaid, KanCare, or KDADS that is due to the Customer's negligence, gross negligence, errors, omissions, breach of contract, and/or intentional misconduct.

**Section 12. Termination of the Agreement**. This Agreement shall remain in effect until the earliest occurrence of one of the following events:

(a) Denial of the Customer's Medicaid and/or KanCare eligibility;
(b) Termination/closure of the Customer's applicable HCBS case;
(c) Termination of the Customer's right to self-direct his/her care;
(d) Termination of the Agreement by the FMS Provider, in accordance with Program requirements, including termination for Medicaid fraud or for failure to pay a state-ordered client obligation;
(e) Termination of the Agreement by the Customer, following written notification from the Customer to the FMS Provider and in accordance with Program requirements; or
(f) The effective date of an agreement between the Customer and another entity that provides FMS to the Customer under the Program.

**Section 13. Third Party Beneficiary**. Though KDADS and the CME (if any) from whom the Customer receives case management services under the Program are not parties to this Agreement, the parties specifically intend that KDADS and the CME (if any) each be a third-party beneficiary and, as a result thereof, further acknowledge and agree that KDADS and/or the CME (if any) may, at their option, enforce the terms of this Agreement.

**Section 14. Assignment**. The parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, FMS Agent, or organization. Subject to that limitation, this Agreement shall be binding upon and inure to the benefit of the parties and their heirs, personal representatives, successors, and assigns.

**Section 15. Amendment**. This Agreement may only be modified by a written agreement signed by the parties hereto. No failure by either party to insist upon the strict performance of this Agreement on one or more occasions shall constitute a waiver of any right or remedy hereunder.

**Section 16. Severability**. The invalidity or unenforceability of any provision of this Agreement shall not affect the other provisions hereof and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

**Section 17. Entire Agreement**. This Agreement has been entered into in good

faith by the parties. This Agreement sets forth the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes any and all prior and contemporaneous negotiations, understandings, and agreements with regard to the subject matter hereof, whether oral or written. In entering into this Agreement, neither the FMS Provider nor the Customer has made or relied upon any representation or provision not set forth herein.

**Section 18. State Law**. The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. The titles of the Sections, Subsections, Paragraphs, and Subparagraphs in this Agreement have been inserted for convenient reference only and shall not affect the construction of this Agreement.

**Section 19. Venue**. For any action to enforce this Agreement by KDADS or CME (if any), venue shall solely be in the District Court of Shawnee County, Kansas. For all other actions to enforce this Agreement, venue shall solely be in the District Court of Sedgwick County, Kansas.

**Section 20. Compliance with Program**. It is the intent of the parties that this Agreement be interpreted to comply with the Program requirements.

**Section 21. Signatures**. This Agreement (and any amendments, modifications, or waivers in respect hereof) may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which shall constitute one and the same document. Facsimile signatures or signatures emailed in portable document format (PDF) shall be acceptable and deemed binding on the parties hereto as if they were originals.

**IN WITNESS WHEREOF**, the parties have executed this Agreement as of the day and year first above written.

_____Provider Representative Signature Date: 01/01/2018

_____ Date:_____
Customer Signature (or Customer's parent, legal guardian or legal representative)

_____
Relationship of the person signing if not the Customer

# All Saints Home Care, Inc.

3425 W. Central
Wichita, KS 67203

Phone: 316-755-1076
Toll Free: 800-941-1076

Fax: 316-755-9076
Web: www.allsaintshomecare.com


IMPORTANT: Please read and follow instructions given in this document.
**Dear Payroll Client:**

We are contacting you regarding very important information you need to be aware of regarding changes that are being implemented in Federal and State regulations and being mandated by KDADS (Kansas Department of Aging and Disability Services). The additional required paperwork in this packet solidifies you as the controlling common law employer of any and all Direct Support Workers that you choose to hire. **These changes are mandatory in order for you to continue to use All Saints Home Care, Inc. as your Payroll Agent.**
Due to these implemented changes in Federal and State regulations, we need you to complete the enclosed paperwork and return to us by June 12th in the enclosed postage paid envelope or in person at All Saints Home Care.

1. The first required form is the Client Tax Identification Worksheet. This Identifies who the Tax ID holder shall be. (Check of each item listed below as you complete it)
   ____ Complete the blanks 1-5
   ____ Sign and Date
   ____ Carefully read the bottom section

2. The second required form is the SS-4, with it, you are allowing ASHC to apply for an Employer Identification Number on your behalf. (Check of each item listed below as you complete it)
   _____ Please complete line 1 and 7b.
   _____ Enter your county on line 6.
   _____ Enter a phone number, sign, date and print your name at the bottom of the form.

3. The third required form is the 2678, with it, you are appointing All Saints Home Care to remit Federal Unemployment, FICA and Medicare taxes on your behalf as well as to file the applicable tax return on your behalf. (Check of each item listed below as you complete it).
   _____ Fill out line 2 with your name and line 4 with your address.
   _____ Sign, date and print your name and phone number at the bottom of page 1.

4. The fourth required form is IRS form 8821, with this form you are authorizing ASHC to speak with the IRS on your behalf regarding any tax withholding issues or questions.
   ____ Enter your name and address and phone number in box 1.
   ____ Sign, date and print your name in box 7

5. The fifth required form is the Kansas Tax Application. This form allows ASHC to file your taxes with the State.
   ____ Leave the top EIN or SSN blank
   ____ Print your name, sign and date.
   ____ Enter SSN, Home Address and daytime phone, and email address.

6. The last required form is a new employment agreement that will replace and supersede the current contract between the employer and the employee, i.e. the Consumer and the DSW. (Check of each item listed below as you complete it)
   ____ Enter the date, the Consumer name as Employer and the DSW name as Employee in the opening paragraph.
   ____ At the end of the document, make sure it is signed and dated by the Consumer as Employer and the DSW as Employee.

# All Saints Home Care, Inc.

3425 W. Central
Wichita, Ks 67203

Phone: 316-755-1076
Toll Free: 800-941-1076

Fax: 316-755-9076
Web: www.allsaintshomecare.com

**Client Tax Identification Number Worksheet**

**Instructions:** Use this worksheet to identify the appropriate Employer/tax identification holder for self-directing client per IRS Rev. Proc. 2013-39. Complete lines 1-5. If there is no guardian, either leave blank or put N/A in space. Sign and Date.

**Tax ID Holder: <u>The Client must be the tax ID holder</u>. The tax ID holder is identified as the common law employer of the personal care attendants.**

1. Name of the Client: _____
2. Social Security Number: _____
3. Date of Birth: _____
4. Physical Address of Employer (Cannot be a PO Box):

   _____

   _____

I have self directed my care before as of 7/1/15:

____YES ___NO

I have a Tax ID number: _____

**Please note that all the following tax forms will still need to be completed even if a tax ID number has already been issued.*

5. Guardian(s) Name (if guardianship is in place): _____ (SUBMIT A COPY OF GUARDIANSHIP PAPERWORK WITH THIS APPLICATION)

**By signing this form, the undersigned authorizes and approves All Saints Home Care, Inc. to apply for federal and state tax identification numbers to properly identify me as the employer of personal care attendants in my Kansas Home and Community Based Services Waiver Self-Direction program:**

_____ _____

***Signature** **Date**

***<u>Signature requirements:</u>** The Client can sign the forms; a guardian can assist the client to sign by the "hand over hand" method to sign all forms. A legal guardian can sign for a client (the client must still be the EIN holder) and must return a copy of court-stamped guardianship paperwork. Contact the office for questions regarding signature requirements.

*Return this completed form for processing. ASHC will obtain federal and state tax ID numbers for the above identified employer. We will maintain this information in your file. These tax ID numbers allow ASHC to with-hold and deposit payroll taxes with the state and federal entities.*

**Note that the tax identification numbers <u>DO NOT</u> impact yours, the Client/Employer, personal taxes. These ID numbers are used to properly identify you as the Employer of your personal care attendants in your HCBS waiver program to the IRS and State of Kansas.**

Return COMPLETED forms to:
**By Mail or in person to: 3425 W. Central, Wichita, KS, 67203**
Please call the office at 316-755-1076 if you need assistance with this form.

Form **SS-4**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

# Application for Employer Identification Number

**(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)**

▶ **See separate instructions for each line.** ▶ **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name
All Saints Home Care, Inc.

4a Mailing address (room, apt., suite no. and street, or P.O. box)
P.O. Box 48397

5a Street address (if different) (Do not enter a P.O. box.)
3425 W. Central

4b City, state, and ZIP code (if foreign, see instructions)
Wichita, KS, 67201

5b City, state, and ZIP code (if foreign, see instructions)
Wichita, KS 67203

6 County and state where principal business is located
, Kansas

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ▶

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN) ___
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶ ___
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶ ___
- ☑ Other (specify) ▶ HCSR
- ☐ Estate (SSN of decedent) ___
- ☐ Plan administrator (TIN) ___
- ☐ Trust (TIN of grantor) ___
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

9b If a corporation, name the state or foreign country (if applicable) where incorporated — State — Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ▶ ___
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☐ Banking purpose (specify purpose) ▶ ___
- ☐ Changed type of organization (specify new type) ▶ ___
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶ ___
- ☐ Created a pension plan (specify type) ▶ ___

11 Date business started or acquired (month, day, year). See instructions.
07/01/2015

12 Closing month of accounting year December

13 Highest number of employees expected in the next 12 months (enter -0- if none).
If no employees expected, skip line 14.

| Agricultural | Household | Other |
|---|---|---|
| 0 | 0 | 0 |

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶ 07/01/2015

16 Check **one** box that best describes the principal activity of your business.
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) HCSR

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☑ No
If "Yes," write previous EIN here ▶

**Third Party Designee**

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: Carrie Laymon
Designee's telephone number (include area code): ( 316 ) 755-1076
Address and ZIP code: 3425 W. Central, Wichita, KS 67203
Designee's fax number (include area code): ( 316 ) 755-9076

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.

Name and title (type or print clearly) ▶

Applicant's telephone number (include area code) ( )

Signature ▶ Date ▶

Applicant's fax number (include area code) ( )

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

**Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.**

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  **Note.** This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

**Part 1: Why you are filing this form...**

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

**Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.**

1 **Employer identification number (EIN)** ☐☐ – ☐☐☐☐☐☐☐

2 **Employer's or payer's name** (not your trade name)

3 **Trade name** (if any)

4 **Address**

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 **Forms for which you want to appoint an agent or revoke the agent's appointment to file.** (*Check all that apply.*)

| | For ALL employees/ payees/payments | For SOME employees/ payees/payments |
|---|---|---|
| Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)* | ☑ | ☐ |
| Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return) | ☑ | ☐ |
| Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees) | ☐ | ☐ |
| Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return) | ☐ | ☐ |
| Form 945 (Annual Return of Withheld Federal Income Tax) | ☐ | ☐ |
| Form CT-1 (Employer's Annual Railroad Retirement Tax Return) | ☐ | ☐ |
| Form CT-2 (Employee Representative's Quarterly Railroad Tax Return) | ☐ | ☐ |

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X **Sign your name here**

Print your name here

Print your title here HCSR

Date / /

Best daytime phone

**Now give this form to the agent to complete.**

Form **8821**

(Rev. March 2015)

Department of the Treasury
Internal Revenue Service

# Tax Information Authorization

▶ **Information about Form 8821 and its instructions is at *www.irs.gov/form8821*.**

▶ **Do not sign this form unless all applicable lines have been completed.**

▶ **Do not use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

OMB No. 1545-1165

**For IRS Use Only**

Received by:

Name

Telephone

Function

Date

**1 Taxpayer information.** Taxpayer must sign and date this form on line 7.

| Taxpayer name and address | Taxpayer identification number(s) | |
|---|---|---|
| | Daytime telephone number | Plan number (if applicable) |

**2 Appointee.** If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ▶ ☐

| Name and address | |
|---|---|
| Carrie Laymon<br>3425 W. Central<br>Wichita, KS 67203 | CAF No. None<br>PTIN<br>Telephone No. 316-755-1076<br>Fax No. 316-755-9076<br>Check if new: Address ☐ Telephone No. ☐ Fax No. ☐ |

**3 Tax Information.** Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

| (a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.) | (b) Tax Form Number (1040, 941, 720, etc.) | (c) Year(s) or Period(s) | (d) Specific Tax Matters |
|---|---|---|---|
| Employment | 940, 940R, 941, 941R, 941X | Qtrs 1,2,3,4 2015-2017 | |
| Employment | W3, W3c, W2, W2C | Qrts 1,2,3,4 2015-2017 | |
| Employment | SS4, 2678 | Qtrs 1,2,3,4 2015-2017 | |

**4 Specific use not recorded on Centralized Authorization File (CAF).** If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ▶ ☐

**5 Disclosure of tax information** (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

**a** If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☑

**Note.** Appointees will no longer receive forms, publications, and other related materials with the notices.

**b** If you do not want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☐

**6 Retention/revocation of prior tax information authorizations.** If the line 4 box is checked, skip this line. If the line 4 box is not checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

**7 Signature of taxpayer.** If signed by a corporate officer, partner, guardian, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ **IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.**

▶ **DO NOT SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

| Signature | Date |
|---|---|
| | HCSR |
| Print Name | Title (if applicable) |

# PLEASE READ & KEEP THE FOLLOWING FORMS FOR YOUR RECORDS.

Please contact the FMS Agent if you have any questions.

# CLIENT CONTRACT

## CONSENT TO CARE

I consent to Financial Management Service/Self-Direct services as provided by All Saints Home Care, Inc.

## RELEASE OF INFORMATION

I authorize All Saints Home Care, Inc. to obtain care records from any health care institution, insurance company, or physician that apply to my care needs within the FMS Agenty. I authorize release of all FMS Agent records to the payer for review, as the payer requires.

## FINANCIAL RESPONSIBILITY

I understand and agree that I am responsible for the following financial obligation:

Client Obligation/Copay: $_____

I understand that if my client obligation changes at any time that I will be billed accordingly including any retroactive changes without any advanced notice.

I understand that if I fail to pay the Client Obligation that All Saints Home Care reserves the right to discontinue my services for non-payment after notifying me and my Insurance Case Manager.

## PAYMENT AUTHORIZATION

I authorize payment for services directly to All Saints Home Care, Inc. when a third party Reimburses for my care. I authorize All Saints Home Care, Inc. to act as my representative concerning my claim or asserted right under Medicaid or county funded programs.

## ACKNOWLEDGEMENT OF WRITTEN MATERIAL

This form has been thoroughly explained to me and I certify that I understand its contents. The FMS Agent has informed me of my PATIENTS RIGHTS AND RESPONSIBILITIES, GRIEVANCE POLICY, ADVANCE DIRECTIVES, & THE NUMBER TO CONTACT THE STATE HOME HEALTH HOTLINE. Copies of all these forms have been provided to me.

### Client Authorization for Consumer Directed Attendant Care
### Authorization to Furnish Information

It is my desire that All Saints Home Care, Inc. has access to any medical records or case management records, which would assist them in the administration of my care needs.

I authorize All Saints Home Care, Inc. to release information to caregivers within their agent, to caregivers that I choose, and to supervisory personnel. This includes HCBS, SRS, and STATE and INSURANCE personnel.

I authorize All Saints Home Care, Inc. to furnish information to other agencies only with my written permission.

I authorize the FMS Agent to release information to my personal physician, whom I have given his/her name to the FMS Agent, as he/she requests.

**FMS Agent Responsibilities**

- The FMS Agent will be responsible to obtain consents for management support from the client.
- The FMS Agent will be responsible to provide time records to caregivers.
- The FMS Agent will be responsible to manage all payment issues (withholding, W2 at year end, FICA, Workers Compensation and Unemployment insurance).
- The FMS Agent will be responsible to perform background checks on all Self Direct workers.
- The FMS Agent will be responsible to offer all clients discrete screening of chosen employees for the following:

**Client Responsibilities**

- The client will be responsible to advertise for or otherwise recruit applicants/employees.
- The client will be responsible to screen and interview for appropriateness of employees.
- The client will be responsible to instruct the attendant on employee conditions and the requirements of the plan of care issued by the insurance company.
- The client will be responsible to explain the payment process and the required approval of their time record to their attendant/employee

- The client will be responsible to sign the time sheets or verify IVR (integrated voice response) time claims for each employee that works hours as indicated in the Plan of Care as approved by your Case Manager.

- The client will be responsible to direct the attendants to the FMS Agent for completion of the employment process.

- The client will be responsible to arrange for back up staff in the event of sickness or time off by your employee/s.

- The client will be responsible to ensure that employees do not begin work until cleared and authorized by the FMS Agent.

**Client Authorization for Consumer Directed Attendant Care**
**Release from Liability**

I acknowledge and release the FMS Agent for liability for the following items:

- Collecting application information
- Interviewing
- Selection of care attendants
- Training of care attendants
- Assigning work hours
- Maintaining time records
- Forwarding time records to the FMS Agent
- Monitoring performance of care attendants
- Dismissing caregivers
- Recruitment of backup replacement attendants

In the event that problems arise which I feel are beyond my experience or ability to manage, I must inform the FMS Agent to enlist their aid. Should the FMS Agent representative see the situation as dangerous or fraudulent or urgent in some other way, they may intervene to end the Personal Care Attendants services or make a report to the appropriate outside agencies, which could include, but not limited to the Medicaid Fraud Hotline, Adult Protective Services, the Client's Case Manager and insurance company, Kansas State Departments of Aging and Disabilities Services and Dept. of Child and Family Services, local law enforcement agencies and the FMS Agent's legal representation.

If All Saints Home Care, Inc. has no knowledge of problems with the Care Attendant I have chosen, and am managing, I absolve the FMS Agent of liability for harm to my household or me.

Urgent items to notify the FMS Agent would include but not be limited to:

- Care attendant performance problems, which result in the client's needs being unmet
- Client not allowing normal performance of services
- Personal Care Attendant having a current drug abuse problem
- Personal Care Attendant having a felony history associated with violence or dishonesty

Please note a Personal Care Attendant will be terminated per the Medicaid guidelines if KDOA investigation report notifies the FMS Agent of ineligibility to work as a Personal Care Attendant for any reason.

## GRIEVANCES

Any client who feels his/her rights have been denied should contact the FMS Agent's Client Care Manager either verbally or in writing (within 30 days). Direct all complaints and questions to the main office at (316) 755-1076

5. The FMS Agent's Client Care Manager shall make every effort to investigate and resolve the complaint within 15 days from the date of notification and notify the client of the results of the investigation.

6. If the FMS Agent''s Client Care Manger has not resolved the complaint, a written complaint should be submitted to the FMS Agent's Administrator.

7. The FMS Agent's Administrator shall take whatever steps are necessary to resolve the complaint and notify the client of the resolution within 30 days of the date of notification.

8. The client shall be advised of the availability of the state's toll-free home health agency hot line, including the telephone number (present on the Client's Bill of Rights and below), its hours of operation, and its purpose, which is to receive complaints or questions about local Home Health Agencies.

**All Saints Home Care**
**Monday - Friday 8-5**
**(316) 755-1076**

**State Home Health Complaint Line**
**Monday - Friday 8 - 5**
**1-800-842-0078**

# Patient Information on Advanced Directives

All adults receiving home care have certain rights guaranteed by law. These rights include the following:
1. You have the right to know in advance what medical care you will be receiving from your home health care provider.
2. You have the right to accept or refuse medical or surgical treatment; and
3. You have the right to prepare legal documents known as Advanced Directives.
Advanced Directives include two types of legal documents:
A.) A Living Will & B.) A Durable Power of Attorney for Health Care.

**A Living Will**- is a legal document that allows you to express your wishes regarding life-sustaining treatment when your condition is terminal and when treatment would merely prolong death. If you prepare a Living Will it will mean that if your attending physician and one additional physician have determined that you will die whether or not life-sustaining procedures are utilized and that application of life-sustaining procedures would only serve to artificially prolong the dying process, that such procedures will not be used. Your wishes as expressed in a Living Will, will only be followed if you are unable for any reason to communicate your wishes yourself (such as if you are unconscious or in a coma). You may, if you wish, cancel and revoke a Living Will at any time by destroying it, by preparing a written revocation, or by verbally revoking it.

A Living Will is a very important legal document. Before preparing a Living Will you may want to discuss it with your family, a close friend, your doctor, and/or a lawyer. If you decide you want to prepare a Living Will, you may contact the office for assistance in obtaining forms or call your attorney for further assistance. The FMS Agent policy is to honor your wishes as expressed by you in your Living Will.

**A Durable Power of Attorney for Health Care**- is a legal document used to appoint another person as your personal representative, or agent, to make health care decisions for you when you cannot make those decisions yourself. This person can accept or refuse treatment for you on your behalf, if you choose to have Durable Power of Attorney for Health Care Decisions, you should name an agent who knows your values and goals relating to treatment and whom you trust to carry out your wishes. This agent does not have to be a family member, but you may choose a family member to be your agent if you like. Talk with your agent about your wishes and confirm that he or she is willing to act on your behalf. Writing a statement that the document is revoked can revoke a Durable Power of Attorney for Health Care. This statement of revocation must be witnessed or notarized.

A Durable Power of Attorney for health care is a very important legal document. If you wish to have one please express this and we will provide you with a form or again you may contact your attorney. The FMS Agent policy is to honor your wishes as expressed by you in your Durable Power of Attorney for Health Care.

In deciding whether to prepare advance directives, you may wish to consult with your doctor. Your doctor can discuss with you your general health, the general prospect for future illnesses, and a range of treatments. Your doctor can also educate you regarding the specific nature of various treatments. This will enable you to decide whether you would want a particular type of treatment or not. You may also want to talk with an attorney since Advance Directives are legal documents that can have very important legal consequences.

If you decide to prepare Advance directives or appoint a Durable Power of Attorney for Health Care be sure your physician, family member, friend, agent, and/or attorney, as well as the home care FMS Agent have copies on file to comply with your wishes.

IMPLEMENTING YOUR RIGHTS
1. FMS Agent will be glad to assist you and provide additional resources for more information.
2. Our FMS Agent will not discriminate against you regardless of your decisions regarding your health care.
3. Our FMS Agent will maintain records as to whether or not you have chosen to execute Advance Directives.
4. Our FMS Agent will comply with all current and any new laws regarding Advance Directives.

PLEASE CONTACT THE DIRECTOR OF NURSING AT (316) 755-1076
TO RECEIVE MORE INFORMATION REGARDING ADVANCE DIRECTIVES

## CLIENT RIGHTS AND RESPONSIBILITIES

It is expected that the adherence to these rights and responsibilities will lead to better client care and satisfaction for the client and the FMS Agent. The rights will be respected by all FMS Agent staff and used in the home care of the client. A copy of these rights will be given to each new client on admission to FMS Agent and will be displayed in the FMS Agent at all times. All clients have the right:

1. To be free from verbal, physical, mental abuse and exploitation.
2. To have personal property respected as well as protected.
3. To be treated with respect, dignity, and recognition of their individual needs for privacy and care.
4. To quality care that is given without discrimination as to race, color, creed, national origin, age, sex, handicap, or disease process.
5. To be encouraged and/or assisted to exercise rights to grievances, changes in policies, or services, without restraint, interference, coercion, discrimination, or fear of reprisal.
6. To associate or communicate privately with anyone of their choice and to have their mail protected from unauthorized handling.

7. To manage personal finances and receive receipts for purchases made on their behalf and at their request.
8. Assurance that all records, communication, and personal information will be kept confidential. Information will not be released without written authorization from the client or legal spokesperson for the client. Records will be made available upon request.
9. There will be access to personal records upon request unless otherwise indicated by the physician in the clinical record.
10. To choose care providers at will and be assured the FMS Agent will communicate with them.
11. To only be admitted to the FMS Agent for services if the FMS Agent can safely and professionally provide services at the level of need required. Clients have the right to expect reasonable continuity of care.
12. To be informed of the type of service and the amount of service including any monies to be paid by client prior to the start of care.
13. To request information about their diagnosis, prognosis, and treatment, including alternatives and risks of the alternatives, in terms that can be easily understood in order for them to make the best possible decision for consensual care.
14. To be informed orally, and in writing when necessary, of new FMS Agent policies, schedule changes, care plan changes, and any other pertinent changes to their care as soon as the FMS Agent becomes aware, and before the change occurs.
15. To choose a personal physician.
16. To participate in planning their care and medical treatment with appropriate instruction and education regarding the plan.
17. To refuse treatment after the consequences of refusal have been explained.
18. To be fully aware of the FMS Agent policies and charges for service, including eligibility for third party reimbursement, prior to receiving care or as soon as eligibility becomes appropriate. Changes which are the responsibility of the client will be clearly explained to the client at the time the FMS Agent becomes aware of the change. The client will be given all information regarding change and others to contact in regards to changes.
19. Not to be transferred or discharged unless medically necessary for the safety and health of others, and in accordance with Medicaid guidelines as referring to non-payment and other issues outlined in service contract.
20. A minimum of 10 days notice prior to transfer or discharge.
21. To be referred elsewhere if the client is denied service for any reason.
22. To exercise his/her rights as a client and in the event the client is unable to exercise his/her rights, the family or legal guardian (providing one has been appointed) may exercise the clients rights on his/her behalf.

| | | |
|---|---|---|
| **All Saints Home Care Complaint Line 316-755-1076** | **Kansas Dept. of Aging & Disability Hotline 1-800-842-0078** | **Medical Fraud & Abuse Hotline 1-866-551-6328** |

## KANSAS AUTHENTICARE POLICY AND PROCEDURES

All workers are required, by the state of Kansas, to check in and out on the IVR phone system for all visits to a client's house where they are helping the client with personal care. The client is not allowed to check the worker in and out, this task must be performed by the worker only. If you feel you have a valid reason for not using the IVR system, please contact the office for approval.

**In order to have a successful claim, the claim must include the following criteria: Worker must use IVR to check in, correct service code selected, worker must use IVR to check out, all applicable activity codes must be entered.**

1. When checking in and out, the worker is required to use the client's phone only. Any visits where an unauthorized phone number has been used to check in or out, may not be paid. When checking in or out, if at any time, the IVR asks for the client ID number, that means you are calling from an unauthorized phone number and you should contact the office.
2. If a client has a new phone number, client and/or worker must report that new phone number to the office by the next business day in order for it to be considered an authorized number.
3. If a worker misses a check in, they must still check out and then contact the office immediately after they have checked out to correct it. If the missed check in is on a weekend or in the evening, the worker should contact the office on the next business day. Until the times can be confirmed with the client, the claim will not be paid.
4. If a worker misses a check out, please contact the office immediately to correct it. If the missed check out is on a weekend or in the evening, the worker should contact the office on the next business day. The worker is still able to check in for their next shift even if they did not check out for the previous shift. Until the times can be confirmed with the client, the claim will not be paid.
5. If a worker fails to check in and out for an entire shift, they should contact the office. A timesheet will be requested, but the timesheet may or may not be paid dependent on the circumstances.
6. Please make sure to reference your client's code sheet for the appropriate service code and activity codes. If a visit is logged under the wrong service code, the claim won't be paid until office staff is able to contact the worker to correct it.
7. Kansas Authenticare will make random calls to client's homes during visits to verify the worker's presence in the home. A representative will ask to speak to the worker. Kansas Authenticare realizes that the worker may not always be there as they may be performing tasks outside of the home such as shopping or laundry.

The client should inform the representative of the worker's whereabouts at that time and it will be documented. Kansas Authenticare also realizes that someone may not be available to answer the phone at all times as the worker may be busy assisting the client with tasks that cannot be interrupted such as bathing or toileting. Again, the representative will just document that there was no answer. If this is a reoccurring issue, the state of Kansas may take further action in investigating the situation.

8. Please remember that any fraudulent activity can result in the client's loss of services and/or legal action taken against the client and/or worker by the state of Kansas. All Saints Home Care, Inc. may also recoup money from the worker at their discretion.
9. The worker has 2 weeks from the date of service (date worked) to submit a time sheet and an additional 2 weeks to dispute incorrect wages. If a worker has an incomplete claim (missing check in/out, etc.) they have 2 weeks from the date of payment to fix the claim. No claims older than 30 days will be paid.

**KANCARE EXPECTATIONS**

All Saints Home Care is sending you this notice to help ensure that you and your chosen worker(s) are up to date and aware of KanCare's expectations for your continued Self-Directed waiver services. The section in italics is the KanCare expectation, immediately following is an explanation of how it applies to you. **Please review all pages of this letter and discuss these items with your worker(s)**.

*The case manager and the beneficiary or his or her representative will use discretion in determining if the selected direct support worker can perform the needed services.*

This means that you, the beneficiary, are responsible for selecting, training and terminating your chosen caregiver. The FMS Agent is available to advise you on how to perform these items, should you have questions or concerns.

*Covered services are limited as defined within the client service worksheet and approved plan of care.*

This means that the chosen caregiver is to be trained by you, and that they can **only be paid for <u>services</u> and <u>time</u> listed on the <u>weekly</u> plan of care.** Please note all Plan of Cares are weekly unless otherwise authorized by the case manager. It is important that your caregiver(s) **perform and report all** of the **activities listed** on the Plan of Care and that the caregiver(s) do not work more than the weekly authorized hours, as Kancare does not allow the FMS Agent to pay for the extra time worked or for when all the services are not performed.

Frail Elderly (FE) a*ttendant care services are limited to a maximum of 48 units (12 hrs.) per day.*
Physical Disability (PD) *attendant care services are limited to a maximum of 40 units (10 hours) per day.*
Traumatic Brain Injury *(*TBI*) attendant care services are limited to a maximum of 40 units (10hours) per day.*

This means your worker(s) cannot claim more than 10 hours for PD, or 12 hours for FE, or 10 hours for TBI in a 24 hour period, without prior authorization from your case manager. It is important that **your worker follows the plan of care and works no more than the allowed amount of hours daily and weekly.**

- **Please note that any hours that your worker claims that are more than the authorized amount, are not allowed to be paid. If they are mistakenly paid, the worker will be required to return the overpayment.**

*This service will not be paid while the beneficiary is hospitalized, in a nursing home, or in any other situation where the beneficiary is not available to receive the service.*

1. **<u>NO time is to be paid to the worker if the client is hospitalized, institutionalized, on vacation</u>**…
    a. *Any claims of working for a client when the client is not present to be cared for could be **considered fraud**,* and **may be reported** as such to Medicaid,

the insurance company, Adult Protective Services and local law enforcement agencies depending on the situation.

b. I*t is the beneficiary's responsibility to train the caregiver and to inform them of this rule.*

**2.** In all types of care it is **both the client and caregiver's responsibility to notify All Saints Home Care within 24 hours of any times the client will not be present for care (hospitalized, institutionalized, on vacation, or unavailable for care for any reason.)**

*More than one direct support worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and case log by the case manager, such as two-man lift for safety issues.*

This means you may not have 2 workers claiming hours at the same time unless prior authorized by your Case Manager.

*Direct support workers are not allowed to work and be paid for multiple HCBS beneficiaries at the same date and time.*

This means your worker may not claim time for 2 people at the same time. **Your worker cannot be paid for either client when this happens. This could also be considered fraud and an investigation will be performed.**

Some additional Authenticare and Kancare expectations for the chosen worker(s):

1. Authenticare is to be used at all times unless you have received prior authorization from the FMS Agent.
2. Time claimed must be the time the worker actually works.
3. Only the worker is allowed to call into Authenticare to clock in and out.

Reports & suspicions of Fraud or Abuse, Neglect

**Please note that the FMS Agent is required to investigate reports and suspicions of fraud and abuse, neglect & exploitation to all applicable legal and state entities.** If a beneficiary (client) is found guilty of committing fraud this may result in a loss of their waiver and Medicaid services. If a worker is found guilty of fraud or abuse of any kind they may be charged with embezzlement and may be unable to work within the Medicaid/Medicare and healthcare industry as well as any other charges the law enforcement deems appropriate.

## Only eligible beneficiaries may receive services.

If you should lose your benefits or insurance or waiver coverage for any reason, you are required to notify us immediately. Any services provided when you are not eligible for

care are not allowed to be paid. This may result in the FMS Agent holding payments and or seeking recoupment from you and/or your worker.

**Client obligations are due by the 20th of every month**

*If you have a client obligation this must be paid no later than the 20th of the month. This is a KanCare and FMS Agent requirement to continue services. All Saints Home Care reserves the right to discontinue services for non-payment after notifying the client and the Insurance Case Manager.*

We would like to thank you for choosing All Saints Home Care. Our hope is that this communication will help clear up some confusion regarding payroll and billing policies, please remember that the staff are here to assist you when you have questions. If you do have any questions regarding this communication or other issues, please do not hesitate to contact the All Saints Home Care main office at 316-755-1076.

Thank You,

Daron Kasselman
CEO
All Saints Home Care, Inc.