CONSUMER DIRECTED SERVICES
EMPLOYMENT APPLICATION INSTRUCTIONS

Please read these easy instructions first!
Your application will not be processed if information is missing.

Before proceeding to the application, please read the following instructions to avoid any misunderstanding regarding your process.

- Do not use white out, erasable ink, red ink, or pencil on the application or other documents.
- Complete the employment application in its entirety. Incomplete applications will not be processed.
- Disclose any and all misdemeanor or felony convictions. You do not need to report minor traffic violations.
- Complete, sign and return the Family Care Safety Worker Registration form.
- Include a one-time fee of $12 in the form of a money order or check made payable to SIL. Fee not required if already registered.
- Complete and sign the Chamber Background Form – If you have not lived in Missouri for the past 5 consecutive years.
- Initial each section of the Attendant Contract.
- Complete the I-9 form – this form CANNOT contain errors or marked-through corrections.
- Bring with you/provide 2 forms of proper and current identification listed on the I-9 List of Acceptable Forms page. Please make sure that both forms of identification have the same name on them.

I consent and acknowledge that Services for Independent Living (SIL) will perform a background screening via the Family Care Safety Registry and Office of Inspector General. Any subsequent screening may result in termination, depending on the results.

I verify that I have fully read and understand the conditions described in this letter. I also understand that I am required to complete all employment documentation before I am authorized to work.

___________________________________________________________  __________________________
Applicant Signature                Date

Updated 2.27.2015 – Business Office
Consumer Directed Services
EMPLOYMENT APPLICATION FOR HEALTH CARE SERVICE

Consumer/Employer: __________________________________________________________________________________________

Name________________________________________________; Aliases________________________________________________
Social Security #__________________________________; All Social Security #s Used______________________________________
Complete Address_____________________________________________________________________________________________
Street Address    City  State  Zip
Email Address________________________________________________________________________________________________

Telephone Number:  (____) ______________ Cell ☐     Alternate Number:  (____) ______________ Cell ☐

Are You 18 Years Of Age Or Older?    Yes   No    (State Requirement: Must be able to show proof you are at
least 18 years of age or older)

Have you lived in Missouri for the last consecutive five years? _____ Yes   _____ No
If NO, Have you worked for an in-home agency since your return? _____ Yes   _____ No
If NO, you must complete the Chamber Background Check

Do you meet the physical and mental demands required to perform specific tasks of the consumer; agree to maintain confidentiality of personal and medical information; are emotionally mature and dependable; are able to handle emergency situations; and are not related by blood, adoption, or marriage? ______Yes _____ No    How are you related to the consumer? _______________________

Do you smoke: _____ Yes   _____ No          Are you willing to work for people who do smoke?  _____ Yes   _____ No

BACKGROUND

Have you ever been convicted of, pled guilty to, or pled nolo contendere (no contest) to an offense other than a minor traffic violation? _____ Yes   _____ No
If you answered yes, disclose below all criminal convictions, findings of guilt, pleas of guilty, and/or pleas of nolo contendere (no contest), except for minor traffic violations.

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Have you ever been listed on the Employee Disqualification List? _____ Yes   _____ No Reason______________________________

Have you ever applied for a Good Cause Waiver? ______Yes    _______No When?  ______________   Why? _________________
Please ask how to complete a Good Cause Waiver when criminal history is disclosed.

Are you registered with the Family Care Safety Registry? ______Yes    _______No      (If no, payment of $12 required)

Do you have a valid MO Driver’s License? _____ Yes   _____ No
Do you have regular access to reliable transportation? _____ Yes   _____ No
Can you read, write and follow directions? _____ Yes   _____ No

Do you prefer working with males, females, or either? __________________

Have you identified a consumer to work for? _____ Yes   _____ No    If yes, whom: ________________________________

Has someone asked you to work for them? _____ Yes   _____ No    If yes, whom: ________________________________

What experience do you have caring for children, individuals with chronic illness, or individuals with disabilities? __________________

Please list any certifications, professional designations and/or licenses you have: ___________________________________________

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

Updated 2.27.2015
<table>
<thead>
<tr>
<th>EMPLOYMENT HISTORY – List the last 5 years of employment with most recent first. If you were previously an attendant employed by an individual receiving Consumer Directed Services, list them as the Company.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Company Name: __________________________; Supervisor: __________________________</td>
<td>Mo/Yr Employed: From ___________ To__________ Position Held: __________________________</td>
</tr>
<tr>
<td>Complete Address __________________________________________________________________________________________</td>
<td>Phone: __________________________ Duties: __________________________ May we contact the employer? Yes___ No___</td>
</tr>
<tr>
<td>Reason for leaving: __________________________________________</td>
<td></td>
</tr>
<tr>
<td>2) Company Name: __________________________; Supervisor: __________________________</td>
<td>Mo/Yr Employed: From ___________ To__________ Position Held: __________________________</td>
</tr>
<tr>
<td>Complete Address __________________________________________________________________________________________</td>
<td>Phone: __________________________ Duties: __________________________ May we contact the employer? Yes___ No___</td>
</tr>
<tr>
<td>Reason for leaving: __________________________________________</td>
<td></td>
</tr>
<tr>
<td>3) Company Name: __________________________; Supervisor: __________________________</td>
<td>Mo/Yr Employed: From ___________ To__________ Position Held: __________________________</td>
</tr>
<tr>
<td>Complete Address __________________________________________________________________________________________</td>
<td>Phone: __________________________ Duties: __________________________ May we contact the employer? Yes___ No___</td>
</tr>
<tr>
<td>Reason for leaving: __________________________________________</td>
<td></td>
</tr>
<tr>
<td>REFERENCES: List three credible references not related to you.</td>
<td></td>
</tr>
<tr>
<td>1) Name: __________________________ Relationship __________________________ Phone #____________________</td>
<td>Complete Address __________________________________________________________________________________________</td>
</tr>
<tr>
<td>2) Name: __________________________ Relationship __________________________ Phone #____________________</td>
<td>Complete Address __________________________________________________________________________________________</td>
</tr>
<tr>
<td>3) Name: __________________________ Relationship __________________________ Phone #____________________</td>
<td>Complete Address __________________________________________________________________________________________</td>
</tr>
<tr>
<td>Acknowledgement:</td>
<td>I certify the answers herein are true and accurate to the best of my knowledge and I hereby authorize performance of pre-employment criminal record checks for employment purposes only. I hereby give consent to performance of a closed records check pursuant to Section 610.120 RSMO. I understand any employment with Consumer is conditioned on my consent to such checks as well as the findings/results of such checks. I hereby release any person or organization conducting such background checks and/or furnishing such criminal record information and Consumer from any and all liability arising out of the conducting of a check or the furnishing or receipt of criminal record information. Any such person or organization may rely on a copy of this release. In the event of employment with Consumer, I understand that false or misleading information given on this application or in interview(s) may result in refusal to hire or, if employed, may result in discharge after its discovery.</td>
</tr>
<tr>
<td>Signature of Applicant: __________________________ Date: __________________________</td>
<td>All qualified applicants will be considered without regard to race, gender (sex), religion, veteran status, disability, age, sexual orientation, national origin, or any other classification protected by law.</td>
</tr>
</tbody>
</table>
**Worker Registration**

**Registration Type**
- [ ] Adoptive Parent
- [ ] Child Care
- [ ] Foster Parent/Family Member of Foster Parent
- [ ] Hospital
- [ ] Long Term Care/Personal Care
- [ ] Mental Health/Psychiatric Hospital
- [ ] Voluntary

Long Term Care / Personal Care Subcategories
- [ ] Adult Day Care
- [ ] Assisted Living Facility
- [ ] Hospice
- [ ] Hospital LTAC/Swing Bed
- [ ] Mental Health – Residential Facility/ICF
- [ ] Nursing Facility/Skilled Nursing
- [ ] Personal Care – Home Health
- [ ] Personal Care – In-Home Services
- [ ] Personal Care – Consumer Directed Services/Center for Independent Living
- [ ] Personal Care – HCY/PDH/DDD/Other

A one-time registration fee of **$12.00** applies to all categories except Foster Parents. Foster Parents must list the Children’s Division county office.

Register only once. If you believe you have already registered, check our website at [www.health.mo.gov/safety/fcsr](http://www.health.mo.gov/safety/fcsr) or call, toll free, 866-422-6872.

**Social Security Number** (Mail copy of card with form.)

**Personal Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Suffix (Jr., Sr., II, III)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maiden Name (If applicable)</th>
<th>Prior Names Used (If applicable, list first and last names.)</th>
<th>Date of Birth (mm-dd-yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>-</td>
<td>[ ] M  [ ] F</td>
</tr>
</tbody>
</table>

**Contact Information**

- **Mailing Address** (Enter your street address or post office box. This address must be different from Employer Address.)

- **City**
- **State**
- **Zip Code**
- **County**

- **Telephone**
- **Email (Optional)**

**Employer Associated with This Registration**

- **My current/potential child care, long term care or mental health care employer is:**
- **No Employer, because I am a(n):**

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Adoptive Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foster Parent/Family Member</td>
</tr>
<tr>
<td></td>
<td>Home Child Care Provider</td>
</tr>
<tr>
<td></td>
<td>Private Pay/Private Duty</td>
</tr>
<tr>
<td></td>
<td>Student</td>
</tr>
<tr>
<td></td>
<td>Volunteer</td>
</tr>
<tr>
<td></td>
<td>Other (Explain: ________ )</td>
</tr>
</tbody>
</table>

**Registration Agreement**

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

**Notice:** The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

**Signature of Applicant** (Must be signed in blue or black ink.)

**Date of Signature** (Must be within six months of submission.)

**Rev. 01/15**

---

**MO 580-2421 (FP)**
WHAT IS THE FAMILY CARE SAFETY REGISTRY?
The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?
Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor. Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?
Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select “Voluntary.” (A “voluntary registrant” is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.
Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.
Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.
Contact Information – List your address including street address or post office box, city, state, ZIP code, and county. Include your telephone number. We will use this information to notify you of registration results and any background screenings conducted.
Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.
Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right.

WHERE DO I SEND MY REGISTRATION FORM?
Send your completed registration form and photocopy of Social Security card and required fee to the Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102. If you have questions, please call the Registry using the toll-free telephone number, 866-422-6872.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?
After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry of any change in your mailing address. You can send address changes to Family Care Safety Registry, P.O. Box 570, Jefferson City, MO 65102.

WHAT IF I DON’T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?
As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?
Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. A Registry worker will first confirm whether the person in question is registered. If the person is registered, the Registry worker will disclose whether the person’s name is listed in any of the background checks pursuant to §210.903, subsection 2. RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).

MO 560-2421 (FP) Rev. 01/15
BACKGROUND CHECK AUTHORIZATION

FCRA NOTICE AND ACKNOWLEDGMENT

IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT

NOTICE REGARDING BACKGROUND INVESTIGATION

_______________________________

(“Company Name”) may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a “consumer report” and/or an “investigative consumer report” which may include, but is not limited to: employment and education verifications; social security number verification; criminal and civil court records; personal interviews; driving records; and/or any other public records or any other information bearing on your character, general reputation, personal characteristics and trustworthiness. These reports may be obtained at any time after receipt of your authorization and, if you are selected, throughout your affiliation with the Company. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. The report will be generated by CHAMBERbackgroundchecks.com (1200 South Outer Road, Blue Springs, MO 64015/816-228-5255) or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are selected, throughout your affiliation with the Company to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION (above) and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT (separate document) and certify that I have read and understand both of those documents. I hereby authorize the obtaining of “consumer reports” and/or “investigative consumer reports” at any time after receipt of this authorization and, if I am selected, throughout my affiliation with the Company. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by CHAMBERbackgroundchecks.com another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile (“fax”) or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. [ ]

Applicants of New York Employers only: I acknowledge that by signing below, I have also received a copy of Article 23-A of the New York Correction Law, in compliance with Article 25 Section 380-g of the New York General Business Law.

California applicants only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. [ ]

<table>
<thead>
<tr>
<th>Full Name</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maiden Name, Previous Names, or Aliases Used:</td>
<td>First</td>
<td>Middle</td>
<td>Last</td>
</tr>
<tr>
<td></td>
<td>First</td>
<td>Middle</td>
<td>Last</td>
</tr>
<tr>
<td></td>
<td>First</td>
<td>Middle</td>
<td>Last</td>
</tr>
<tr>
<td></td>
<td>First</td>
<td>Middle</td>
<td>Last</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number:</th>
<th>Date of Birth:</th>
<th>Driver’s License/ID State:</th>
<th>Driver’s License/ID Number:</th>
</tr>
</thead>
</table>

Please provide ALL residential addresses for the past seven (7) years.

Current Address: From

Previous Address: From/To

Previous Address: From/To

Previous Address: From/To

Previous Address: From/To

Previous Address: From/To

Previous Address: From/To

Previous Address: From/To

Previous Address: From/To

<table>
<thead>
<tr>
<th>Contact Telephone Number:</th>
<th>Check here if there are more addresses you have lived at in the last 7 years.</th>
</tr>
</thead>
</table>

SIGNATURE: DATE:
ATTENDANT CARE CONTRACT

This Attendant Care Contract ("Contract") is made by Services for Independent Living and the Attendant/Employee identified in line B. above who will be employed by the Consumer/Employer identified in line A. above. Read thoroughly and initial after each section.

1. Definitions. In order to make this Contract more easily understood, certain terms are defined and various responsibilities are described as follows:

a.) The term "Consumer/Employer" means the individual identified in line A. above, who, requires Attendant care services in his/her home. Hereafter, the Consumer/Employer will be referred to as "Consumer." Consumer is the employer of Attendant/Employee and as such is responsible for directing, managing, scheduling (within the parameters of authorized service hours), and supervising Attendant/Employee. Consumer is responsible for maintaining and reviewing all timesheets connected with Attendant/Employee's hours of service for accuracy, and Consumer is responsible for promptly forwarding the same to Services for Independent Living. Consumer is responsible for keeping the timesheet in their home for monitoring purposes. Consumer, through the fiscal intermediary, will pay the Attendant/Employee at a rate chosen by Consumer for services authorized in Consumer’s Plan of Care and by this Contract. ____

b.) The term “Attendant/Employee” means the individual identified in line B. above, who, as a party to this contract, agrees to provide Attendant care services to Consumer. Hereafter, the Attendant/Employee will be referred to as “Attendant.” ____

c.) The term “consumer-directed services” (CDS) or “consumer directed care” means those services that Consumer needs to have provided to him/her within his/her home in order to achieve independent living within the community. Consumer-directed services may include but are not limited to helping Consumer with eating, dressing, meal preparation, toileting, bathing, grooming, transferring, and specific health maintenance tasks, as well as some incidental housekeeping tasks that insure Consumer’s health and safety, like grocery shopping and laundry. The consumer-directed services that Attendant will perform pursuant to the CDS program will be described and authorized in the Consumer’s Plan of Care. A copy of the pertinent parts of the Plan of Care will be provided to Attendant. ____

d.) The term “Services for Independent Living” means the agency signing this Contract. Hereafter, Services for Independent Living will be referred to as “SIL.” It is recognized as a vendor of Consumer Directed Services and enrolled as an Organized Health Care Delivery System with the Department of Health and Senior Services, Division of Senior and Disability Services. SIL is authorized to provide administrative support to Consumer and is authorized to enter into payroll service contracts with payroll service companies to provide fiscal intermediary services as set forth below. ____
The term “fiscal intermediary” means a payroll service company, under contract with SIL, retained to perform “fiscal intermediary services”. These include calculating the amount that an attendant is to be paid by Consumer, writing payroll checks (or making direct deposits), witholding and paying state and federal income taxes to the appropriate authorities, withholding and paying Social Security (FICA) and Medicare payments and/or Consumer’s portions as is required by law or regulations and paying them to the appropriate authorities, and making unemployment/workers compensation insurance payments, as well as withholding/paying those amounts as may be required by law or regulations from time-to-time. The fiscal intermediary will provide Attendant with a written summary of all deductions and payments made. The fiscal intermediary will prepare and provide Consumer and Attendant with end-of-year tax information and forms within the time prescribed by law, such as W-2’s, so that Consumer and Attendant may comply with all tax filing requirements. The fiscal intermediary will maintain copies of all records required by law or regulations for tax and other purposes, and these shall be the official records documenting the employer/employee (Consumer/Attendant) relationship.

2. Purpose and background information. The purpose of this Contract is to allow the Consumer to interview, hire, direct, manage, schedule (within the parameters of authorized service hours for purposes of the CDS program), supervise, and discharge his/her Attendant. SIL is a vendor of consumer-directed services and as such it is authorized by the Missouri Department of Health and Senior Services to provide administrative support and case management for consumer-directed services. SIL may contract with payroll service companies to act as a fiscal intermediary. The fiscal intermediary will act as an agent for and provide payroll services for Consumer, as explained herein. Consumer will employ Attendant to work in Consumer’s home, at the direction and under the supervision of Consumer, to provide the attendant care services described and authorized in Consumer’s Plan of Care. Because of the work arrangement contemplated in this contract, Attendant is an employee of Consumer, and not an independent contractor. It is, therefore, necessary that Consumer, through the fiscal intermediary, withhold and pay all income taxes required by law, as well as all other withholdings or payments that employers generally make in connection with employees in order to comply with applicable laws and regulations. The fiscal intermediary will perform intermediary services as described above and prepare payment for hours worked to Attendant on behalf of Consumer.

3. Basis for payment. Attendant agrees to perform the consumer-directed services described and authorized in Consumer’s Plan of Care at an hourly rate chosen by Consumer of $7.65 to $9.15/hour, which rate may be increased from time-to-time. Attendant will be paid through a fiscal intermediary only for those consumer-directed services described and authorized in Consumer’s Plan of Care for the particular month at issue. Medicaid will provide funds to the fiscal intermediary to pay Attendant on behalf of Consumer for authorized attendant care services actually performed for Consumer.

4. Method of payment. SIL will provide Consumer with documents authorizing payment on behalf of the Consumer for the consumer-directed services described and authorized in Consumer’s Plan of Care. The documents will set forth the maximum number of hours to be worked for purposes of the CDS program during a specific time period; and the applicable time period for performance of the consumer-directed services. SIL will also provide Consumer with timesheets to record Consumer’s name, Attendant’s name, dates and times of services delivered, types of activities performed at each visit, Attendant’s signature for each visit and Consumer’s signature verifying service delivery for each visit.

Payroll will be processed bi-weekly. At the end of each payroll period, Consumer will review and approve the completed and legible timesheet and forward the same to SIL. Timesheets must be received by SIL the following Tuesday after the end of a payroll period to be included in the applicable payroll.
SIL does not receive the timesheets within the prescribed time, then payment may not be processed until the next payroll, and Attendant’s payment may be delayed. 

It is imperative that Consumer and Attendant accurately record and report services and hours. Falsification or misrepresentation on any timesheet constitutes fraud. Payments made on behalf of Consumer as a result of inaccurate/false timesheets will be recouped from Attendant and/or Consumer to the extent permitted under applicable law. Any incidents of apparent fraud will be reported to Medicaid and/or other appropriate authorities.

5. Conditions and understandings of Contract. Attendant understands an investigation to determine if fraud has occurred with respect to timesheets related to the CDS program may be performed and agrees to provide any requested assistance with respect to any such investigation. Additionally, as Medicaid funds are used, in whole or in part, to pay Attendant, the Missouri Department of Social Services and the U.S. Department of Health and Human Services, and/or its/their designee(s), have the right to evaluate, through inspection or other means, the consumer-directed services rendered and reimbursed hereunder.

Attendant understands and agrees that he/she is not an employee of SIL. Attendant will not represent that he/she is an employee of SIL. Attendant understands and agrees that pursuant to this Contract, he/she is employed solely by Consumer.

Attendant understands that, depending on the results of a background check or information revealed on an application, Attendant may not be eligible to provide services and receive payment under the CDS program unless and until Attendant obtains a Good Cause Waiver. Attendant shall not receive any wages through SIL or a fiscal intermediary on behalf of Consumer for services rendered unless and until they are eligible for employment for purposes of the CDS program. The Attendant shall not hold SIL or a fiscal intermediary responsible for failing to process or pay any wages on behalf of Consumer for services provided to Consumer prior to fulfilling CDS program pre-employment responsibilities.

6. Liability for work related injury/illness. Attendant understands and agrees that Attendant and/or Consumer is/are solely responsible for any injuries or illness Attendant sustains while providing consumer-directed services and/or acting within the scope of his/her employment, and that neither SIL nor the State of Missouri has any liability for such injuries or illness.

7. Mandated Reporter. Attendant agrees and understands that he/she is required by law to report suspected abuse, neglect, and/or exploitation as determined under Sections 660.00, 565.188, 208.912, 208.915 and 198.070 RSMo to MISSOURI RESPONSE SYSTEM, 1-800-392-0210.

8. Direction and supervision of Consumer. Attendant understands and agrees that he/she will perform the consumer-directed services specified in Consumer’s Plan of Care under the direction and supervision of Consumer on such dates and at such times as agreed upon by Attendant and Consumer; however, for purposes of reimbursement through the CDS program, the service time shall not exceed the number of hours authorized for service.

9. Termination. Attendant understands and agrees that he/she is an at-will employee of Consumer and that he/she can resign at any time and Consumer can discharge him/her at any time for no reason or any lawful reason unless Consumer and Attendant separately agree to more limited circumstances and notice requirements under which the employment relationship and this Contract can be terminated. This Contract shall terminate upon the ending of the employment relationship between Consumer and Attendant. Consumer or Attendant shall inform SIL when Consumer’s employment relationship with Attendant has ended.
10. Confidentiality. Attendant understands that Consumer is entitled to have his/her personal and health care information treated with confidentiality. Attendant agrees to protect and maintain Consumer’s confidentiality in accordance with HIPPA any other applicable laws. Under no circumstances will Attendant discuss or disclose any Consumer’s personal or health care information without legal authorization. Consumer’s right to confidential treatment of personal and health care information survives the termination of this Contract.

11. Hospital stays. Should services be provided by Attendant to Consumer during Consumer’s hospital stay, Consumer is solely responsible for paying the Attendant and those services shall not be reimbursable on behalf of Consumer through SIL or a fiscal intermediary. Should an Attendant receive wages during the Consumer’s hospital stay through SIL or a fiscal intermediary on behalf of Consumer, SIL shall exercise the legal right to recoup the entire amount to the extent allowed by law as identified by the Department of Health and Senior Services and/or Missouri HealthNet. Additionally, Attendant and Consumer will be referred to the Central Registry Unit and/or Office of Attorney General for an investigation of record falsification.

12. Miscellaneous provisions. This Contract shall be interpreted in accordance with and governed by the laws of the State of Missouri. The place of contract is the county where SIL has its principle office.

13. Subsequent background screenings. State law mandates an initial background screening for every potential attendant. Additionally, a subsequent background screening is performed upon the attendant’s request to work for additional consumers. Depending on the results of a background check or information revealed on an application, Attendant may be ineligible to provide services and receive payment under the CDS program unless and until Attendant obtains a Good Cause Waiver. The invalidity or unenforceability of any portion or provision of this Contract shall not effect, impair, or render unenforceable any other portion or provision. It is intended that each provision herein that is invalid or unenforceable as written be valid and enforceable to the fullest extent possible.

The captions in this Contract are for convenience only and are not to be construed as substantive parts of this contract.

This contract shall not be modified except in writing signed and dated by all parties.

At the time of termination of this contract, Attendant agrees to promptly provide Consumer with current timesheet information so that the last payroll for Attendant may be completed.

14. Signatures. BY SIGNING BELOW YOU ACKNOWLEDGE YOU HAVE READ THIS CONTRACT, YOU ACCEPT IT, UNDERSTAND IT, AND AGREE TO ITS TERMS.

__________________________________________________________________________  __________________________________________________________________________
Signature: Employee/Personal Care Attendant  Printed Name

__________________________________________________________________________  __________________________________________________________________________
Signature: SIL Representative/Title  Printed Name

__________________________________________________________________________  __________________________________________________________________________
Signature: Employer/Consumer  Printed Name
Employee/Attendant Regular Hourly Rate Selection

I, ________________________________, the Employer/Consumer for my Employee/Attendant ________________________________, choose to pay my Employee at the designated starting regular hourly rate as I have set forth below.

I understand I can pay my Employee any regular hourly rate within the range of $7.65 to $9.15 and choose to pay my Employee at the regular hourly rate of $__________________ per hour. I understand I can later increase my Employee’s regular hourly rate during his/her employment for me up to the maximum rate of $9.15 per hour.

I understand Services for Independent Living will assume I want to pay my Employee at the starting regular hourly rate of $7.65 if I do not return this form completed and signed to Services for Independent Living before the date my Employee starts performing work for me pursuant to the CDS program that is authorized by my plan of care.

___________________________________________________________________________ Employeer/Consumer Signature:       __________

___________________________________________________________________________ Date:
Consumer/Self Directed Services: Authorization to Release Information

To assist Services for Independent Living with reducing fraud, waste and abuse, I hereby give permission to them to access specific employment records from my current employer. Records to be disclosed by my employer shall only include those containing my name, hours worked, and time in/time out. All other records are not to be released unless I provide additional written consent prior to the release of requested records.

I have listed my current employers below, I assure Services for Independent Living that I will update my employment record upon changing employers.

Company Name: ________________________________________________________________
Address: _______________________________________________________________________
Phone: ________________________________________________________________________
Supervisor: ____________________________________________________________________

Company Name: ________________________________________________________________
Address: _______________________________________________________________________
Phone: ________________________________________________________________________
Supervisor: ____________________________________________________________________

Company Name: ________________________________________________________________
Address: _______________________________________________________________________
Phone: ________________________________________________________________________
Supervisor: ____________________________________________________________________

The above Release of Information shall remain in effect until revoked in writing. All records obtained shall be open to inspection by the State of Missouri and/or its agents or designees.

_________________________________________________________  ________________________
Employee Signature and Title       Date

Updated 9.2014
**DIRECT DEPOSIT ENROLLMENT FORM**

<table>
<thead>
<tr>
<th>Print your name</th>
<th>Date of Birth (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Address</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Mailing Address (P.O. Box)</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Email Address</td>
<td>Driver's License Number and State</td>
</tr>
</tbody>
</table>

**NOTE:** If you only receive mail at a PO Box, you must also provide a physical address. *One phone number is required for registration.*

Please check one box below for the electronic deposit of your payroll.

- [ ] ReadyFUND$ Paycard: Please deposit 100% of my pay to my ReadyFUND$ card.
- [ ] Savings: Please deposit $___________ or %___________ to my personal savings account and the balance will be deposited either into checking or on my ReadyFUND$ card.
- [ ] Checking Account: Please deposit 100% of my pay to my checking account. (please attach a voided check)

I hereby authorize my Payroll agent, Services for Independent Living (the Company) to deposit any amounts owed me by my employer by initiating credit entries to my account at the financial institution indicated above. Further, I authorize Bank to accept and to credit any entries indicated by Company to my account. In the event that the Company deposits funds erroneously into my account, I authorize Company to debit my account the amount not to exceed the original amount of the erroneous credit.

For my convenience, I request that SERVICES FOR INDEPENDENT LIVING directly deposit my wages/salary earned from my employer into my bank account. I agree to hold SERVICES FOR INDEPENDENT LIVING harmless from loss and to indemnify it, limited to the amount of deposit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such a manner as to afford Company and Bank a reasonable opportunity to act on it. If the person receiving the direct deposit from Payroll Agent cancels the agreement, from the regular checking or savings account, a ReadyFunds card will be issued in its place. There will no longer be paper checks available.

By signing this I confirm that the above information is complete and accurate.

---

Signature          Date

Updated 9.2014