

- HCBW
- SCL
- ABI

Kentucky Consumer Directed Option Employee/Provider Contract

I (*employee name*) _____, have agreed to work
under the employment of (*employer name*) _____.

Duties under this contract will consist of the following:

Home and Community Supports:

- Respite (*HCB, SCL, and ABI*)**
Total Approved Hours per month _____
- Personal Care (*HCB and ABI*)**
Total Approved Hours per month _____
- Homemaker (*HCB only*)**
Total Approved Hours per month _____
- Attendant Care (*HCB only*)**
Total Approved Hours per month _____
- Community Living Supports (*SCL only*)**
Total Approved Hours per month _____
- Companion Services (*ABI only*)**
Total Approved Hours per month _____

Community Day Support Services:

- Adult Day Training (*SCL only*)**
Total Approved Hours per month _____
- Support Employment (*SCL only*)**
Total Approved Hours per month _____

I agree to provide the above listed services as required by my employer at the rate of \$_____ per hour. I will not exceed the total approved amount noted above.

I accept the check(s) as payment in full for the service(s) or items purchased. I will not make additional charges to or accept additional payments from the consumer(s).

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

I understand that DMS will not be liable for any injuries or losses incurred while providing services.

I understand that I may not be approved as a CDO provider if my background check detects that I have pled guilty to or been convicted of committing a sex crime or a violent crime.

I understand that I may not be approved as a CDO provider if my name is listed on the Kentucky Nurse Aid Abuse Registry.

For the Supports for Community Living (SCL) and Acquired Brain Injury (ABI) programs **only**, I understand that I may not be approved as a CDO provider if my name is listed on the Department for Community Based Services Division of Protection and Permanency's Central Registry.

I understand that I must maintain employee/employer confidentiality.

I understand this is an at-will contract and either party may terminate this agreement at any time.

I understand that I must notify my employer of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

I have received any and all training required by my employer in order to provide the necessary services as described in this contract.

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer and myself.

Employee/Provider Date _____
Employer/Member Date