Family Together Alliance, LLC
Independent Contractor Application

Family Together Alliance, LLC does not discriminate on the basis of age, race, sex, color, religion, national origin, disability or any other applicable status protected by state or local law. It is our intention that all qualified applicants be given equal opportunity and that selection decisions be based on job-related factors.

Please answer each question completely and accurately. Please PRINT, except for signature.

Date: _________________ Last Name: _______________________ First Name: _______________________ Middle Initial: ______

Home Phone #: _______________________ Cell Phone #: _______________________ Email: ______________________________

Current Street Address: ____ State: ___________ Zip Code: ________________

Job Applied for: ____

Are you 18 years of age or older? • Yes • No *(If hired, you may be required to submit proof of age)* Social Security #: ___________________

If hired, can you provide proof that you are eligible to work in the United States? • Yes • No

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Have you ever applied to Family Together Alliance, LLC before: • Yes • No If yes, when? ________________________________

Have you ever worked as an independent contractor for Family Together Alliance, LLC before? • Yes • No If yes, when? _______

Have you ever been convicted of a crime, including DUIs, with the exclusion of minor traffic violations: • Yes • No
If yes, please provide details: ____

____

Do you have a valid Driver's License: • Yes • No If yes, please submit a copy of your Driver's License with this application.

Has your Driver's License previously been suspended or revoked? • Yes • No If yes, please provide details: __________________

____

Name and Address of Schools	# of Years Completed	Diploma/Degree/Certificate	Subjects Studied

High School/GED: ____

College/University: ____

Vocational/Technical: ____

What skills or additional training do you have that are related to the job for which you are applying? ____________________

____

Previous Employment History *(Please provide employment history for the past 5 years; please attach additional pages if necessary)*:

Name of Employer: ___________________________________ Job Title/Duties: ____

Address: ____ Supervisor Name: ___________________________________

Telephone #: ____________________ Reason for Leaving: ___________________________________ Start Date: ______________ End Date: ______________

Name of Employer: ___________________________________ Job Title/Duties: ____

Address: ____ Supervisor Name: ___________________________________

Telephone #: ____________________ Reason for Leaving: ___________________________________ Start Date: ______________ End Date: ______________

Name of Employer: ___________________________________ Job Title/Duties: ____

Address: ____ Supervisor Name: ___________________________________

Telephone #: ____________________ Reason for Leaving: ___________________________________ Start Date: ______________ End Date: ______________

Name of Employer: ___________________________________ Job Title/Duties: ____

Address: ____ Supervisor Name: ___________________________________

Telephone #: ____________________ Reason for Leaving: ___________________________________ Start Date: ______________ End Date: ______________

Family Together Alliance, LLC
Independent Contractor Application

Have you ever worked or attended school under any different name? • Yes • No
If yes, please provide names used: ____

Are you currently employed? • Yes • No If yes, may we contact your current employer? • Yes • No
Have you ever been fired from a job or asked to resign? • Yes • No If yes, please explain: ______________________

____

Please provide 3 references that we may contact (non-relatives):

Name: ____________________ Address: ______________________________ Phone #: ________________

Name: ____________________ Address: ______________________________ Phone #: ________________

Name: ____________________ Address: ______________________________ Phone #: ________________

I certify that all information provided is accurate and true to the best of my knowledge. I understand that any false information may disqualify me from consideration for employment and may result in my dismissal, if discovered at a later date.

I understand that in order to be considered for independent contractor status, Family Together Alliance, LLC requires background checks be completed through the Colorado Bureau of Investigation and CAPS. If so desired, I may ask for a copy of the results from either/both of the background checks. I understand that I may not begin independent contracted work until each background check has been completed and results furnished to Family Together Alliance, LLC. I understand that negative results on my background check may disqualify me from independent contractor status.

I understand that this application and any subsequent independent contractor status does not create a contract of independent contracted status nor guarantee independent contractor status for any definite period of time. I understand that my status will be considered "Independent Contractor". I understand that I am an at-will independent contractor and thus can be hired/terminated at the will of Family Together Alliance, LLC, with or without cause and with or without notice.

I will not be offered benefits through Family Together Alliance, LLC. If applicable, Family Together Alliance, LLC will furnish a 1099 tax form no later than January 30th, of the year following the year worked. No taxes will be taken out of any monies owed at each pay day during the year.

I have read, understand and consent to these statements:

____ ____________________
Signature Date

INDEPENDENT CONTRACTOR-
INTERMITTENT SERVICES PROVIDER CONTRACT

* This Agreement establishes an Independent Contractor Relationship between Family Together Alliance and the Independent Contractor Day Program Care Provider and *not* an Employee Relationship *

PROVIDER: Family Together Alliance

CONTRACTOR: ____

EFFECTIVE DATE: ____

TERMINATION DATE: ____

PAYMENT REIMBURSEMENT RATE:
CES Waiver Services:
Respite: $22/Hr;
Day Respite: $225/Day;
Basic Homemaker: $19/Hr;
Enhanced Homemaker: $28/Hr;
Community Connector: $37/Hr;

SLS Waiver Services:
Respite: $22/Hr;
Day Respite: $225/Day;
Basic Mentorship: $41/Hr;
Personal Care: $22/Hr

PROVIDER is a Program Approved Provider Agency (PASA) for the state of Colorado providing services and supports for people affected by intellectual and developmental disabilities under the Home and Community Based CES, SLS and/or DD waivers.

CONTRACTOR provides direct support services as outlined in the CLIENT's Service Plan for people affected by intellectual and developmental disabilities in accordance with the PROVIDER policies and procedures and State statute and regulations. The term CONTRACTOR where used in this document refers to, and is equally binding upon, all parties signing as CONTRACTOR. All terms, conditions, restrictions, and limitations throughout this document shall apply equally to all parties signing as CONTRACTOR. Nothing shall construe, nor is intended to construe, where the term CONTRACTOR appears that it is only binding or applicable to one party where two names and signatures are listed.

CLIENT is an individual who is receiving the CONTRACTOR's services.

TERMS AND CONDITIONS

CONTRACTOR agrees to provide CLIENT with those services described below**.** The services will be provided throughout the term of this Agreement, unless this Agreement is terminated earlier in accordance with the specifications detailed below. If more than one individual signs this Agreement as "CONTRACTOR", then each individual is jointly and severally obligated to perform all obligations of CONTRACTOR. A breach of this Agreement by either individual shall be deemed a breach by both individuals.

1) CONTRACTOR agrees to:

a) Provide all services and documentation in accordance with applicable State statutes and regulations, and PROVIDERS's policies and procedures. The manner, time, and place that the services are performed shall otherwise be at the discretion of CONTRACTOR.

b) Complete and supply PROVIDER with documentation of completion of all required trainings.

c) Complete required documentation and submit monthly, unless otherwise requested, documenting the services provided. Service documentation will include start and end times, a description of the services provided in accordance with the goals outlined in the service plan, with language and sufficient detail to justify the hours billed. Service log notes will be reviewed by the PROVIDER and any deficiencies will be rectified within 48 hours. Failure to supply proper documentation may jeopardize payment for services billed and can also be grounds for termination of this contract.

d) CONTRACTOR must have any equipment and/or internet access that is necessary to complete documentation in accordance with PROVIDER policies and procedures.

e) Provide input and participate in the development of CLIENT's individual Service Plan as required by State regulations.

f) Address all aspects of CLIENT's life as identified by CLIENT's individual Service Plan.

g) Provide services to CLIENT in a manner that respects the dignity and rights of the individual following the standards outlined in the Rights Policy and Procedure, Supplemental Rights handout as well as the Residency Agreement.

h) Treat as confidential all information regarding CLIENT and disclose such information only to persons with a legitimate need to know. CONTRACTOR will execute and abide by the terms of the Health Insurance Portability and Accountability Act of 1996 including but not limited to Standards for Privacy of Individually Identifiable Health Information known as "Privacy Rules" as defined under such Act.

i) Assure availability of safe and reliable transportation for CLIENT, if providing transportation services or services in the community requiring transportation in the CONTRACTOR vehicle. The CONTRACTOR will provide certification of vehicle liability insurance as required by law (if personally owned vehicle is provided) and provide proof that any driver transporting CLIENT is currently licensed to drive.

j) CONTRACTOR has the obligation to notify PROVIDER if he/she loses his/her license or vehicle insurance, and, if this occurs, CONTRACTOR must notify PROVIDER who will assist the CONTRACTOR to identify alternative means of transportation for the CLIENT. If during the term of the Agreement the CONTRACTOR becomes unable to transport the CLIENT, this may be deemed a "breach" of the Agreement and if the transportation problem is not resolve, the Agreement may be terminated. CONTRACTOR will maintain vehicle insurance coverage as outlined in the Agency's Policy and Procedure. CONTRACTOR will sign transportation acknowledgement.

k) Obtain required training in regard to CLIENT's needs; State rules, regulations and policy, and specific PROVIDER policies and procedures, with the cost of such training the responsibility of CONTRACTOR.

l) Assume the cost and repair of property damage to CONTRACTOR'S home, property or vehicle for

damages caused by CLIENT, acknowledging that behavior management plans must identify CLIENT's responsibility for any repayment for damages caused by CLIENT.

m) Schedule service hours with the CLIENT, attend all scheduled shifts, notify the PROVIDER of any missed shifts and communicate clearly and timely any need to change scheduled shifts.

n) Provide at least 24 hours' notice for any change to scheduled shift and make all reasonable attempts to cover that shift to avoid cancellation.

o) Maintain eligibility as required by State regulations and statue and by PROVIDER for the provision of care to CLIENT. CONTRACTOR will further furnish to PROVIDER appropriate documentation confirming that CONTRACTOR and all individuals providing respite care satisfy all training, medical certification, background checks (criminal, OIG, CAPS, motor vehicle) and other requirements.

p) Promptly report to PROVIDER and to the appropriate State agency as required by regulation, any other act or condition required to be reported by State regulations, including any abuse, neglect, injury or illness involving CLIENT.

q) Cooperate fully with investigations conducted by the State, Law Enforcement, Community Centered Boards (CCB), or PROVIDER.

2) PROVIDER agrees to:

a) Provide or assist CONTRACTOR in obtaining any orientation or special training necessary due to the unique needs of CLIENT.

b) Provide reasonable support services and consultation as requested by CONTRACTOR.

c) Provide copies of any applicable rules, regulations, policies, procedures·, accreditation standards or plans as requested by CONTRACTOR, or as required to meet the contractual requirements of funding agencies.

d) Provide monitoring of services in accordance with State and Federal statutes and regulations, local requirements, accreditation requirements, and PROVIDER Policies and Procedures.

e) Provide or assist CONTRACTOR in obtaining orientation or special training necessary to use any required software system to complete CLIENT related documentation.

3) Term. This Agreement shall be for a term of one year beginning on the Effective Date and continuing to the Termination Date, provided that this Agreement may be terminated prior to the Termination Date as follows:

a) Immediately by PROVIDER upon written notice to CONTRACTOR:

(1) Based on Policies and procedures, state rules regulations and statues

(2) PROVIDER determines that CONTRACTOR has violated the duty to protect the health, safety or welfare of CLIENT.

(3) If CONTRACTOR is found to have violated any state and/or federal law that threatens the funding of the services provided to the client or funding of PROVIDER in general.

(4) If a license or certification required of CONTRACTOR under State law has either been suspended

or terminated, or has lapsed.

(5) If CLIENT expresses the desire for a change to his or her placement and it is determined by the Interdisciplinary Team that a change in placement would be in the best interest of CLIENT.

(6) Upon reduction, termination or withholding of funding relied upon by the PROVIDER to provide care services for CLIENT.

(7) If PROVIDER determines after reasonable inquiry that CLIENT's rights or individualized plan is not being strictly followed.

(8) If CONTRACTOR has failed to correct a breach within 30 days of notification by PROVIDER of the breach unless PROVIDER has provided the CONTRACTOR a written notice of an extension to remedy the breach beyond the initial 30 days.

(9) If required in any other instance by State or Federal mandate or law.

(10) For any reason, upon thirty (30) days prior written notice to a Party by:

1. CONTRACTOR
2. PROVIDER
3. CLIENT or CLIENT's legal guardian.

(11) Within 48 hours after termination for any reason of this Agreement, CONTRACTOR agrees to deliver CLIENT to either PROVIDER, or to CLIENT's legally appointed guardian, together with all funds, paperwork, and personal property of CLIENT in the possession of CONTRACTOR. CLIENT's Interdisciplinary Team will also provide adequate transition planning and support as appropriate.

4) Payment for Services. "CONTRACTORS will be paid biweekly or monthly using the rate documented on the first page of this Agreement.

a) CONTRACTOR will present to PROVIDER on the first business day of each month for monthly payments and the first AND sixteenth of the month for biweekly payments, or as otherwise scheduled, complete records pertaining to CLIENT in the manner prescribed by PROVIDER. No payment will be made unless complete records are presented to PROVIDER. Subject to verification that services have been provided to CLIENT, CONTRACTOR will then be paid biweekly or monthly at the rate established on the first page of this Agreement. Payment dates are provided in a separate document in your New Care Provider Document Package. Those CONTRACTORS choosing biweekly payment will be paid the 15th of the month and the last day of the month. If one of those dates falls on the weekend, payment will be made the Friday prior. CONTRACTOR must choose biweekly or monthly payments prior to providing services.

b) CONTRACTOR must provide these records in according to PROVIDER's policies and procedures. This may include providing the records electronically through a specific software system. PROVIDER will provide CONTRACTOR reasonable notice of any change in PROVIDER policies and procedures regarding the manner of record creation or delivery, and CONTRACTOR must comply with announced changes by the due dates indicated by PROVIDER.

c) Records received on or after the 10th of the month will not be processed for payment until the following month.

d) CONTRACTOR must make every effort to assure that all documentation provided to PROVIDER is true and accurate as any billing errors may be considered Medicaid fraud and result in automatic termination of this Agreement for cause.

e) CONTRACTOR further agrees to promptly remit to PROVIDER any payments made due to omission, error, fraud, or which may be subsequently denied as the result of CONTRACTOR's failure to deliver the required services, or through other improper billing.

f) *Voluntary Termination:* Upon voluntary termination of this Agreement by either party, CONTRACTOR will be paid through the period for which services were provided when client resided in the CONTRACTOR's home, prorated for any period less than a full month.

g) *Involuntary Termination:* Upon involuntary termination of this Agreement, CONTRACTOR will be paid through the period of time for which services were provided when client resided in the CONTRACTOR's home, prorated for any period less than a full month.

(1) *Breach of Contract:* PROVIDER may withhold payments otherwise due CONTRACTOR until such time as the breach is cured. If the Agreement is terminated due to such breach, payments due CONTRACTOR may be withheld by PROVIDER and applied against damages incurred by PROVIDER resulting from CONTRACTOR's breach. The amount withheld shall not limit the amount of damages to which PROVIDER may lawfully be entitled.

5) Breach. Upon written notice by PROVIDER of a breach of this Agreement, CONTRACTOR will undertake those actions necessary to immediately cure the breach. A breach will include CONTRACTOR's failure to comply with any applicable law, regulation, standard, policy or procedure. If a breach is not cured within 30 days from the date of the written notice, this Agreement will be terminated unless PROVIDER provides CONTRACTOR with written notice of an extension beyond the initial 30 days to cure said breach.

6) Notice. Any notice required by either party in this Agreement will be deemed sufficient if hand-delivered or mailed by first class mail to the following addresses:

a) PROVIDER:

b) CONTRACTOR:

7) Indemnification. CONTRACTOR agrees to indemnify, defend and hold PROVIDER, and its employees, officers, agents, and assignees or contracting parties harmless from any and all liability, claims or causes of action of any kind related to the services provided under this Agreement. ·

8) Independent Contractor Status. The Parties to this Agreement affirm that the relationship between PROVIDER and CONTRACTOR is that of an independent contractor. In fulfilling the terms of this Agreement, no agent, employee or family member of CONTRACTOR shall be or shall be deemed to be an agent or employee of PROVIDER with respect to services provided hereunder. CONTRACTOR will be solely responsible and shall indemnify and hold- PROVIDER harmless for CONTRACTOR's acts and omissions and the acts and omission of CONTRACTOR'S agents, family members, employees, and guests during the performance of this Agreement.

9) Insurance. CONTRACTOR agrees to maintain adequate insurance coverage including liability, property (as applicable for services provided) and vehicle insurance (as applicable for transportation services or services requiring transportation to and from activities).

10) No Contractual Interference. CONTRACTOR acknowledges that PROVIDER has an ongoing interest in the well-being and continued provision of services to CLIENT. CONTRACTOR will not take any action, or fail to act in any way that would reasonably be expected to jeopardize PROVIDER’s ability to continue to provide services to CLIENT.

11) Proprietary Information. All information which CONTRACTOR has a reasonable basis to consider property of PRORVIDER or which is treated by PROVIDER as confidential shall be presumed to be "Proprietary Information". This includes, but is not limited to, contracts, forms, policies, procedures, handbooks, and trainings.

CONTRACTOR agrees that any Proprietary Information acquired in the course of conducting the Contractual obligations under this Agreement is the property of PROVIDER and may not be shared or used without express, written permission of an authorized representative of PROVIDER.

12) CLIENT Movement. If CLIENT or CLIENT's guardian desires to terminate this Agreement and seeks to transfer to another service provider, CONTRACTOR shall strictly adhere to the policies and procedures described above in termination processes.

13) Complete Agreement, Binding Effect. This Agreement shall represent the complete understanding between the Parties, subject to State law and regulations, PROVIDER policies and procedures and CLIENT's individual Service Plan. This Agreement is intended to supersede all prior agreements between the parties relating to the subject matter of this Agreement. No amendments or changes may be made to this Agreement unless in writing and signed and dated by both parties.

By signing this Agreement, CONTRACTOR also acknowledges having received applicable regulations, policies and procedures, and CLIENT’s individual program plan.

This Agreement shall be governed according to the laws of the State of Colorado which CONTRACTOR’s services are provided and shall be binding.

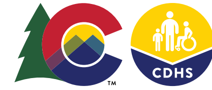
In witness hereof, the Parties have executed this Agreement to become effective on the day indicated on this day ______________, 20__.

PROVIDER:	CONTRACTOR:
______________________________	______________________________
Printed Name	Printed Name
______________________________	______________________________
Signature	Signature
______________________________	______________________________

Date of Signing

Date of Signing

Written Authorization to Request a CAPS Check



COLORADO
Adult Protective Services
CAPS Check Unit

This employer is required to request a check of the Colorado Adult Protective Services (APS) data system (CAPS) during the hiring process of new employees who provide direct care to at-risk adults. Additionally, this employer has statutory authority to request a CAPS check for current employees or volunteers. The CAPS check will alert the employer as to whether or not the employee or volunteer has a substantiated finding as a perpetrator of mistreatment of an at-risk adult, to include physical abuse, sexual abuse, caretaker neglect, exploitation, and/or harmful act.

More information on the CAPS check requirement can be found in the Colorado Revised Statutes (C.R.S.) under §26-3.1-111 and in the Colorado code of Regulations (CCR) under 12 CCR 2518-01. Written authorization is required from the applicant, employee, or volunteer using this form. Please complete this form in its entirety. Knowingly providing inaccurate information on a CAPS check request is a class 1 misdemeanor pursuant to §18-1.3-501, C.R.S. You may ask the employer for a copy of this form for your records.

EMPLOYER INFORMATION (To be completed by the employer.)

Employer Name: ______________________________

CAPS Check Employer ID # (XXX-##########): ______________________________

REQUESTOR INFORMATION (To be completed by the employer.)

Requestor Name: ____________________ Requestor Title: ____________________

Requestor Phone Number: ____________________ Requestor Email: ____________________

APPLICANT/ EMPLOYEE/VOLUNTEER INFORMATION (To be completed by the applicant, employee, or volunteer.)

First Name: ____________ Middle Name: ____________ Last Name: ____________

Maiden Name/Previous Name(s)/Alias: ______________________________

Date of Birth: ____________ SSN (Last 4 digits): ____________ DORA License #: ____________
(required for all licensed professionals)

Provide the Name(s) of Your Previous Employer(s) Over the Past Five (5) Years: ______________________________

____

APPLICANT/EMPLOYEE/VOLUNTEER CONTACT INFORMATION

Must provide at least one (1) personal phone number and one (1) email address.

Employee's Personal Email Address: ______________________________

Employee's Work Email Address: ______________________________

Employee's Cell Phone: ____________________ Employee's Home Phone: ____________________

Employee's Work Phone: ____________________ Employee's Work Phone Extension: ____________

APPLICANT/EMPLOYEE/VOLUNTEER CURRENT ADDRESS

Current Address Start Date (DD/MM/YYYY): ____________________

Current Street and Number (No PO boxes): ____________________

Current Address City: ____________________ Current State: __________ Current Zip/Postal Code: __________

APPLICANT/EMPLOYEE/VOLUNTEER PREVIOUS ADDRESS HISTORY

All applicants, employees, and volunteers are required to provide five (5) years of residential history, regardless of whether in the U.S. or abroad. If you lived outside the US in the past five (5) years, provide the international address(es), including the name of the city and country. If you listed less than 5 years at your current address, please list the previous addresses for the past 5 years. Use another sheet of paper, if necessary.

Previous Address Start Date *(DD/MM/YYYY)*: __________ Previous Address End Date *(DD/MM/YYYY)*: __________

Previous Street and Number *(No PO boxes)*: ____________________

Previous City *(City and country for international addresses)*: ____________________

Previous State *(Not required for international addresses)*: __________ Previous Zip Code *(Use "00000" for international addresses)*: __________

Previous Address Start Date *(DD/MM/YYYY)*: __________ Previous Address End Date *(DD/MM/YYYY)*: __________

Previous Street and Number *(No PO boxes)*: ____________________

Previous City *(City and country for international addresses)*: ____________________

Previous State *(Not required for international addresses)*: __________ Previous Zip Code *(Use "00000" for international addresses)*: __________

Previous Address Start Date *(DD/MM/YYYY)*: __________ Previous Address End Date *(DD/MM/YYYY)*: __________

Previous Street and Number *(No PO boxes)*: ____________________

Previous City *(City and country for international addresses)*: ____________________

Previous State *(Not required for international addresses)*: __________ Previous Zip Code *(Use "00000" for international addresses)*: __________

I, ____________________, by my signature below, authorize the employer referenced above to request a CAPS check to determine if I have a substantiated finding as a perpetrator of mistreatment of an at-risk adult. I acknowledge that a substantiated finding resulting from such a check, unless the finding was expunged through a successful appeal, shall be provided to the person directly involved in the employer's hiring process and may be used to inform their hiring decision of me. I acknowledge notification may occur through CAPS to this employer, for the duration of my employment or volunteer assignment with them, of any future substantiated findings against me. I understand that willfully providing false information on this form is a misdemeanor 1 penalty, punishable as outlined in §18-1.3-501, C.R.S. I declare under penalty of perjury under Colorado Law that this CAPS Check Request Form, including supporting documents, has been examined by me and is true, correct, and complete.

Signature: ____________________

Date: ____________________

COLORADO
Adult Protective Services
CAPS Check Unit

Direct Deposit Authorization Form
Family Together Alliance, LLC

PO Box 1441, Castle Rock, Colorado, 80104
(720) 310-8462
admin@familytogetheralliance.com

Name on Account: ____

Mailing Address: ____

City, State, Zip: ____

Name of Bank: ____

Account #: ____

9-Digit Routing #: ____

Amount: $________________or ______________%

Type of Account: _______________________(Checking or Savings)

- -

(if more than 1 account fill-in below)

Name on Account: ____

Mailing Address: ____

Name of Bank: ____

Account #: ____

9-Digit Routing #: ____

Amount: $________________or ______________%

Type of Account: _______________________(Checking or Savings)

- -

Attach a voided check for each bank account to which funds should be deposited (if necessary)

Family Together Alliance, LLC is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee's Signature and Date: ____

Electronic Visit Verification (EVV) Live-in Caregiver Attestation Form

Instructions

Validity of information on this form must be reviewed and updated by the provider agency or Financial Management Service (FMS) vendor with the member and caregiver annually. Changes must be documented immediately. The provider agency or FMS vendor is responsible for maintaining this form and any relevant evidence for Department verification and auditing. If live-in caregiver status is not valid at any time, the attendant and provider agency or FMS vendor shall collect EVV per state rule. Service dates prior to the completion of this form and required approvals must have a corresponding EVV record. The Department reserves the right to deny or revoke live-in caregiver status for an EVV exemption when information on completed form does not meet Department specification or if information is found to be misrepresented or falsified.

On the attached form, complete all informational fields with the most current and accurate information available. Part A, Part B, or Part C attest to the determination of live-in caregiver status by meeting the criteria of a Federal entity definition or Department approval of extenuating circumstances. Only Part A, Part B, or Part C need to be completed per form. Mark your selection and provide the most relevant evidence for that definition. If attesting to an extenuating circumstance, contact the Department for pre-approval*. "Reside" for Part B means the place of residence or the place used most often for domestic activities outside of work such as sleeping, living, eating, etc. "Premise" for Part B means any property, dwelling, apartment, or structure that the member resides in.

Permissible Supporting Documentation (Minimum of 1):

Copy of both state ID's showing shared residency; address listed on tax returns; automobile registration; voter registration card, utility or other household bill showing individuals address; bank account statement; or Medicaid records. All documentation must be current or have a date within the last three months. Other documentation may be used upon Department approval.

**Extenuating circumstance exceptions may be approved for time less than one year. Approval of extenuating circumstance may take 2 - 4 weeks.*

COLORADO
Department of Health Care Policy & Financing

Live-In Caregiver Attestation Form

Electronic Visit Verification (EVV) is a technology solution which electronically verifies visit information to ensure that home or community-based services are delivered to members needing those services by documenting the precise time service begins and ends. Section 12006 of the 21st Century Cures Act requires all state Medicaid agencies implement an EVV solution. Federal guidance permits states to exempt live-in caregivers from EVV. This exemption may or may not apply to the parent or family of a member, depending on living arrangement.

Caregiver/Member Information
Caregiver Name:
Last 5 digits of Caregiver SSN:
Member Name:
Member Medicaid ID#:
Shared Address:
Provider or FMS Vendor Information
Provider Agency or FMS Vendor Name:
Medicaid Provider ID:
Provider Agency or FMS Vendor Representative Name:

A **live-in caregiver** is a caregiver who permanently or for an extended period of time resides in the same residence as the Medicaid member receiving services. Live-in caregiver status is determined by meeting requirements established by either the U.S. Department of Labor, Internal Revenue Service, or Department-approved extenuating circumstances. Documentation of live-in caregiver status must be collected and maintained by the provider agency. Live-in caregiver status is established by the member/caregiver relationship and only pertains to relationships where documentation has been provided and approved.

Part A: IRS Determination[1]

☐ I declare that I am an individual care provider receiving payments under a qualifying state Medicaid program as defined in IRS notice 2014-7 for care I provide to an individual (whether or not related) living in the individual care provider's home.

Part B: DOL Determination[2]

☐ "Permanently" – I reside on the same premises as the individual I provide services to permanently by living, working, and sleeping on premises seven days per week and have no home of my own.

☐ "Extended Periods of Time" - I reside on the same premises as the individual I provide services to for an extended period of time by living, working, and sleeping on premises for five days a week (120hrs or more) OR I spend less than 120 hours per week working and sleeping on premises, but I spend five consecutive days or nights residing on premises.

Part C: Extenuating Circumstances Determination

The Department, at its discretion, permits live-in caregiver establishment beyond the above definitions. Pre-approval is required. Email EVV@state.co.us

☐ Joint Custody	☐ Members transitioning out of residential service
☐ Child in Foster Care	
☐ Other:	
Part C Department Approver:	
Part C Date of Approval:	

Signing this document is an attestation that, to the best of my knowledge, the information on this form is true and accurate. I understand that falsifying information may result in a Program Integrity investigation or recoupment of paid claims.

Caregiver Signature:
Member or Authorized Representative Signature[3]:
Provider Agency:
Effective Date:

[1] IRS Notice 14-07 effective January 03, 2014 regarding §131 of the Internal Revenue Code

[2] Department of Labor Application of the Fair Labor Standards Act to Domestic Service, Final Rule; Fact Sheet #79B: Live-in Domestic Service Workers Under the Fair Labor Standards Act (FLSA)

[3] For CDASS, this signature line is intended for the Employer of Record.

For FMS Vendor Processing Only
Date of form and supporting documentation receipt:
Effective date of EVV exemption:
By dating this form, the FMS vendor confirms the receipt and review of documentation. Review includes verification that all necessary information is included, not a validation of validity. Section required to be completed by FMS at processing. If section is not completed, EVV must be submitted per state rule. Electronic stamp acceptable.

Family Together Alliance, LLC

Request for Exemption from COVID 19 Vaccination

Requirements and Instructions

Effective October 31, 2021, vaccination against COVID-19 is a condition of employment with Family Together Alliance, LLC. A medical exemption may be granted upon receipt of a completed form (below) and supporting documentation when requested.

- Requests for a medical exemption will be reviewed by and adjudicated by an independent review committee comprised of multidisciplinary Family Together Alliance, LLC providers.
- Priority will be given to the advisory opinions of established and credible medical professional organizations including but not limited to the American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetrics and Gynecology, Society for Fetal and Maternal Health, and the Centers for Disease Control.
- In those cases where a medical exemption is not consistent with the advisory opinion of an established and credible medical professional organization, the request must be supported by an attestation of need signed and certified by a licensed health care provider, not related to the submitter, and whose specialty is appropriate to the associated condition.
- Documentation related to the medical condition for which any exemption is requested may not be more than 3 months old.
- Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits vaccination. The assigned expiration is at the sole determination of Family Together Alliance, LLC.
- While Family Together Alliance, LLC will carefully review all requests for medical exemptions, approval is not guaranteed.

Family Together Alliance, LLC will carefully review each request and determine if the request should be granted. After your request has been reviewed and processed, you will be notified by email if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination contraindication occur, a new request with updated documentation is required. Decisions are final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

Individuals with an approved exemption may be required to comply with COVID-19 testing and other preventive requirements as specified by [HEALTH CENTER NAME/ACRONYM].

Family Together Alliance, LLC

Request for Exemption from COVID 19 Vaccination

Medical exemption process:

- Read the CDC COVID-19 Vaccine Information;
- Complete and sign the following page of this form;
- Have your Licensed Health Care Provider complete the provider section of this form if you feel it will be required;
- Submit the completed documents.

Request For Medical Exemption from Covid-19 Vaccination

To request an exemption from receiving the COVID-19 vaccination for medical reasons, please complete this form and return to admin@familytogetheralliance.com.

Employee Name: ______________________________ Email: ____________________________

Phone Number______________________ Department/Location: ________________________

Incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.

I am requesting an exemption from receiving the COVID 19 vaccine due to the following medical condition: ____

Please initial next to each of the statements below:

— I request exemption from the COVID-19 vaccination requirements due to my current medical condition described above. I understand and assume the risks of non-vaccination.

— I understand that as I am not vaccinated, to protect my own health, the health of my coworkers and of our patients, I will comply with assigned COVID-19 testing requirements and other preventive guidance.

— I acknowledge that I have read the CDC COVID-19 Vaccine Information.

— I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination, as determined by Family Together Alliance, LLC in reviewing the request.

— If required, I authorize my licensed health care provider to provide Family Together Alliance, LLC with medical information about my medical exemption for the COVID-19 vaccination.

— I certify that the information I have provided in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to termination if any of the information I provided in support of this exemption is false.

Signature: ____________________________________ Date: _____________________________

Family Together Alliance, LLC

Request for Exemption from COVID 19 Vaccination

Health Care Provider Attestation for Medical Exemption from COVID 19 Vaccination

Attention Health Care Provider:

A condition of employment with Family Together Alliance, LLC is COVID-19 vaccination. ___________________________________ (insert patient's name) is requesting a medical exemption from COVID-19 vaccination. A medical exemption may be allowed for certain recognized contraindications. Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request.

By signing and providing further information below, you are attesting that the physical condition of this patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Medical condition or circumstances: ____

____

Duration of the medical condition or circumstance and reason why vaccine is contraindicated:

____

____

____

____

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Family Together Alliance, LLC

Request for Exemption from COVID 19 Vaccination

Certification

I certify that ____ (patient name) has the above contraindication and support the request for a medical exemption from COVID-19 vaccination at Family Together Alliance, LLC.

Provider Information

Medical Provider Name: ____

Medical Provider Specialty: ____

Signature: ____ Date: _________________________________

Provider License Number: ____________________

Practice Name: ____

Address: ____

Phone number: ______________________________

Family Together Alliance, LLC

Request for Exemption from COVID 19 Vaccination

Request for Religious Exemption from COVID 19 Vaccination

Requirements and Instructions

Effective October 31, 2021, vaccination against COVID-19 is a condition of employment with Family Together Alliance, LLC. A religious exemption may be granted if the employee (1) holds sincere religious beliefs which are contrary to the practice of vaccination, (2) completes this form, and (3) provides the required documentation to support the exemption request.

Family Together Alliance, LLC is committed to providing equal employment opportunities without regard to any protected status and a work environment that is free of unlawful harassment, discrimination, and retaliation. As such, Family Together Alliance, LLC is committed to complying with all laws protecting employees' religious beliefs and practices.

When requested, Family Together Alliance, LLC may provide an exemption/reasonable accommodation for employees' religious beliefs and practices which prohibit the employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for Family Together Alliance, LLC or pose a direct threat to the health and/or safety of others in the workplace and/or to the requesting employee.

To request an exemption related to Family Together Alliance's COVID-19 vaccination requirements, please complete this form, and return it to Human Resources. This information will be used by Human Resources to engage in an interactive process to determine eligibility for and to identify possible accommodations. If an employee refuses to provide such information, the employee's refusal may impact Family Together Alliance's ability to adequately understand the employee's request or effectively engage in the interactive process to identify possible accommodations.

While Family Together Alliance, LLC will carefully review all requests for religious exemptions, approval is not guaranteed. Family Together Alliance, LLC will carefully review each request and determine if the request should be granted. After the request has been reviewed and processed, the employee will be notified, in writing, if an exemption has been granted or denied. The decision is final and not subject to appeal. Employees are permitted to reapply if new documentation and information should become available.

Individuals with an approved exemption may be required to comply with COVID-19 testing and other preventive requirements as specified by Family Together Alliance, LLC.

Family Together Alliance, LLC

Request for Exemption from COVID 19 Vaccination

Request For Religious Exemption from Covid-19 Vaccination

To request an exemption from receiving the COVID-19 vaccination for religious beliefs and practices, please complete this form and return to admin@familytogetheralliance.com

Employee Name: _____________________________ Email: ____________________________

Phone No: ___________________ Department/Location: ______________________________

Please provide a statement explaining the religious beliefs or practices that necessitate this request for exemption. Please state why the COVID-19 vaccination requirement is contrary to your sincerely held religious beliefs or practices and provide examples of past adherence to these beliefs or practices:

If there is a religious leader or member willing to attest to the premise for this request for a religious

exemption, please provide their contact information:

Name: ________________________________ Telephone: __________________________

Email Address: ____

Please attach any written materials you may have that describe the religious beliefs or practices and their objections/prohibitions to the COVID-19 vaccine.

Verification and Accuracy

I have read and understand Family Together Alliance's Requirements and Instructions regarding religious exemption. My religious beliefs and practices which result in this request for a religious exemption are sincerely held. I verify that the information I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action up to termination.

I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace and/or to me, or if it creates an undue hardship on Family Together Alliance.

Name (Print) _________________________________

Signature ____ Date: ____/____/____

Family Together Alliance
Pay Period Calendar 2024

Jan-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	Pay Day 1/16/24 due to holiday 15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Feb-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

Mar-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Apr-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

May-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Jun-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

Jul-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Aug-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Sep-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4		6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Oct-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Nov-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Dec-24						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Time Sheets Due

Pay Day