Employer of Record Designation and Acknowledgement Form

HOME AND COMMUNITY-BASED SERVICES
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

IMPORTANT INFORMATION

The Community Choices Waiver (CCW) offers you as a participant of the CCW program, or your legal guardian, as appropriate, the opportunity to take an active role in the management of select services through the participant-directed services option. You may choose to direct your own services or appoint another individual you trust to serve as the designated Employer of Record (EOR) to direct services on your behalf.

You must complete this form in order to designate another individual to be your EOR to make decisions and act on your behalf concerning the employer duties and responsibilities under the participant-directed services option. Your EOR is authorized to act on your behalf with respect to these employment related functions whether or not you are able to act for yourself.

Your EOR cannot make other financial or healthcare decisions on your behalf. If you have questions about the authority you are granting to your EOR, you should seek legal advice before signing this form.

DESIGNATION OF EOR

I, _____, (Name of Participant) name the following person as my EOR:

Name of EOR:_____

EOR's Address:_____

EOR's Telephone Number:_____

SPECIFIC AUTHORITY

I grant my designated EOR specific authority to act for me and conduct these employment related functions with regard to my participant-directed services:

1. Recruit potential employees;
2. Ensure employees successfully complete all required training;
3. Specify any additional qualifications, criminal history and background investigation standards, and/or training requirements;
4. Select and hire employees;
5. Set employee wages within the limits of the program;
6. Determine employee duties consistent with the CCW Service Index and within the limits of the program;
7. Create and maintain a job description for each employee;
8. Verify employee enrollment with Financial Management Service and obtain necessary approval status prior to beginning service delivery
9. Orient, train, and instruct employees in their duties;
10. Schedule and manage service delivery to remain within the participant-directed budget;
11. Supervise employees;
12. Evaluate and manage employee performance;
13. Verify time worked by employees and approve timesheets; and
14. Discharge and/or terminate employees.

I understand that designating these duties does not limit or discharge my responsibility or liability for truthfulness, completeness, and accuracy of all claims presented to Wyoming Medicaid by me or on my behalf. This agreement does not eliminate the possibility of penalties under applicable state and federal law for fraudulent, false, or misleading claims.

EFFECTIVE DATE

This EOR designation is effective immediately unless I have stated otherwise in the Special Instructions.

SIGNATURE AND ACKNOWLEDGMENT

_____

Participant Signature* and Date:

_____

Participant Name Printed:

_____

Participant Address:

_____

Participant Telephone Number:

If a participant has a legal guardian who has decision-making authority, they must sign the form and present documentation of guardianship or legal representation.

COMMUNITY CHOICES WAIVER
PARTICIPANT DIRECTION EMPLOYER AGREEMENT

Participant direction is an optional service delivery method that offers participants of the Community Choices Waiver (CCW) an alternative to receiving services through traditional provider agencies. Participant direction means the participant (or their legal guardian or designated employer of record, as appropriate) is granted decision making authority over certain waiver services and accepts the responsibility for taking a direct role in managing them.

EOR DUTIES

When you accept your responsibility as an EOR, you agree to:

1. Act in good faith;
2. Act loyally for the participant's benefit;
3. Act with care and perform the duties and responsibilities of the designated employer of record with competence and diligence;
4. Act within the authority granted in this power of attorney;
5. Do what you know the participant reasonably expects you to do or, if you do not know the participant's expectations, act in the participant's best interest;
6. Cooperate with any person that has authority to make healthcare decisions for the participant to do what you know the participant reasonably expects or, if you do not know the participant's expectations, to act in the participant's best interest;
7. Avoid conflicts that would impair your ability to act in the participant's best interest;
8. Not serve or be reimbursed as a provider of Medicaid services to the participant;
9. Not receive compensation to perform the duties and responsibilities of the designated employer of record;
10. Ensure that claims submitted by employees are accurate and do not contain false claims, statements, or concealment of material facts;
11. Disclose your identity as an EOR whenever you act for the participant by writing or printing the name of the participant and signing your own name;
12. Not represent yourself as an employee or agent of the State of Wyoming or the Financial Management Services (FMS) agency; and
13. Not assign or delegate the duties and responsibilities of the designated employer of record to another person or entity.

SPECIAL INSTRUCTIONS (OPTIONAL)

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By signing this form, you acknowledge that:

1. You have received and read the Participant Direction Employer Manual.
2. You understand and agree to comply with the guidelines of the Participant Direction Employer Manual, as revised or updated in the future.
3. You understand that non-compliance with the CCW program standards may result in disciplinary action up to and including involuntary termination from the participant-directed service option.
4. You understand that you serve as the legal employer, and do not have the authority to assign or delegate the employer duties and responsibilities to another person or entity.
5. You are responsible for managing services within the authorized participant-directed budget. You understand that timesheets submitted in excess of the authorized budget will not be paid by the Financial Management Services (FMS) agency.
6. You shall not represent yourself as an employee or agent of the State of Wyoming or the FMS agency.
7. You may be held personally responsible under applicable state and federal laws for any fraudulent, false, or misleading claim that you make or present to Wyoming Medicaid, and may be responsible for repayment of any funds.

SIGNATURE AND ACKNOWLEDGMENT

Employer of Record Signature and Date

Employer of Record Name Printed

Participant/Legally Authorized Representative Signature* and Date

Participant/Legally Authorized Representative Name Printed

If a participant has a legally authorized representative who has decision-making authority, they must sign the form and present documentation of guardianship or legal representation.