

MOMMY'S LITTLE GIRL LLC

CLIENT POLICIES AND PROCEDURES

MOMMYS LITTLE GIRL LLC

John "Jack" Ewert

P.O. Box 582

Hutchinson, MN. 55350

Phone 320-583-3799

Fax 612-568-9757

Email jewert@hutchtel.net

Web Site: <http://www.mlgpca.com>

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MOMMYS LITTLE GIRL LLC

John "Jack" Ewert
Hutchinson, MN. 55350

RECIPIENT POLICIES, PROCEDURES, AND TEMPLATES

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Minnesota Home Care Bill of Rights

**PER MINNESOTA STATUTES, SECTION 144A.44. TO BE USED BY PROVIDERS OF
HOME CARE SERVICES EXEMPTED FROM LICENSURE UNDER MINNESOTA
STATUTE 144A.46, SUBD.2.**

Statement of Rights

A person who receives home care services has these rights:

1. The right to receive written information about rights in advance of receiving care or during the initial evaluation visit before the initiation of treatment, including what to do if rights are violated.
2. The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services.
3. The right to be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices, including the consequences of refusing these services.
4. The right to be told in advance, of any changes in the plan of care and to take an active part in any changes.
5. The right to refuse services or treatment.
6. The right to know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services.
7. The right to know, in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay.
8. The right to know what the charges are for services, no matter who will be paying the bill.
9. The right to know that there may be other services available in the community, including other home care services and providers, and to know where to go for information about these services.
10. The right to choose freely among available providers and to change providers after services have begun, within limits of health insurance, medical assistance, or other health programs.



ADVANCE DIRECTIVE NOTICE

Questions and Answers About Health Care Directives

Minnesota Law

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury. The information that follows talks about health care directives and how to prepare them. It does not give every detail of the law.

What is a Health Care Directive?

A health care directive is a written document that informs other of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a health care directive.

Why Have a Health Care Directive?

A health care directive is important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Must I Have a Health Care Directive? What Happens if I Don't Have One?

You don't have to have a health care directive. But, writing one helps to make sure your wishes are followed.

You will still receive medical treatment if you don't have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a health care directive.

How Do I Make a Health Care Directive?

There are forms for health care directives. You don't have to use a form, but your health care directive must meet the following requirements to be legal:

- Be in writing and dated.
- State your name.
- Be signed by you or someone you authorize to sign for you, when you can understand and communicate your health care wishes.

- Have your signature verified by a notary public or two witnesses.
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make.

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

Information about how to obtain forms for preparation of your health care directive can be found in the Resource Section of this document.

I Prepared My Directive in Another State. Is It Still Good?

Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. But requests for assisted suicide will not be followed.

What Can I Put in a Health Care Directive?

You have many choices of what to put in your health care directive. For example, you may include:

- The person you trust as your agent to make health care decisions for you. You can name alternative agents in case the first agent is unavailable, or joint agents.
- Your goals, values and preferences about health care.
- The types of medical treatment you would want (or not want).
- How you want your agent or agents to decide.
- Where you want to receive care.
- Instructions about artificial nutrition and hydration.
- Mental health treatments that use electroshock therapy or neuroleptic medications.
- Instructions if you are pregnant.
- Donation of organs, tissues and eyes.
- Funeral arrangements.
- Who you would like as your guardian or conservator if there is a court action.

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

Are There Any Limits to What I Can Put in My Health Care Directive?

There are some limits about what you can put in your health care directive. For instance:

- Your agent must be at least 18 years of age.
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for the naming of the agent in your directive.
- You cannot request health care treatment that is outside of reasonable medical practice.
- You cannot request assisted suicide.

How Long Does a Health Care Directive Last? Can I Change It?

Your health care directive lasts until you change or cancel it. As long as the changes meet the health care directive requirements listed above, you may cancel your directive by any of the following:

- A written statement saying you want to cancel it.
- Destroying it.

- Telling at least two other people you want to cancel it.
- Writing a new health care directive.

What If My Health Care Provider Refuses to Follow My Health Care Directive?

Your health care provider generally will follow your health care directive, or any instructions from your agent, as long as the health care follows reasonable medical practice. But, you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agency to arrange to transfer you to another provider who will follow the agent's directions.

What If I've Already Prepared a Health Care Document? Is It Still Good?

Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney and mental health declarations.

The law changed so people can use one form for all their health care instructions.

Forms created before August 1, 1998, are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

What Should I Do with My Health Care Directive After I Have Signed It?

You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a health care directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

What if I believe a Health Care Provider Has Not Followed Health Care Directive Requirements?

Complaints of this type can be filed with the Office of Health Facility Complaints at 651-201-4200 (Metro Area) or toll-free at 1-800-369-7994.

What if I Believe a Health Plan Has Not Followed Health Care Directive Requirements?

Complaints of this type can be filed with the Minnesota Health Information Clearinghouse at 651-201-5178 or toll-free at 1-800-657-3793.

How to Obtain Additional Information

If you want more information about health care directives, please contact your health care provider, your attorney, or the Minnesota Board on Aging's Senior LinkAge Line® 1-800-333-2433.

A suggested health care directive form is available on the internet at: <http://www.mnaging.org/>.

MOMMYS LITTLE GIRL LLC

John "Jack" Ewert
Hutchinson, MN. 55350

SPEND-DOWN NOTICE AND POLICY

If Medical Assistance requires a client to pay a spend-down to the Agency, there is a legal obligation to pay for the spend-down to the Agency. If the consumer or responsible party receives a bill from the agency, that amount is due and payable immediately, in the form of a personal check, money order or cashier's check.

Failure to pay the spend-down may result in termination of personal care services with the Agency. Failure to pay the scheduled spend-down payments may result in legal action. Spend-downs must be paid each month before services will be provided. Employees will not be paid if the spend-down obligation has not been fully paid.

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John "Jack" Ewert
Hutchinson, MN. 55350

COMPLAINT PROCEDURE

In accordance with Minnesota Law, the Agency provides all its clients with the following information regarding receiving, investigating, and resolving complaints.

- ✓ You have the right to complain to the Agency if you are unhappy about the services you receive, or if you are unhappy with a decision made by the Agency, including a decision not to hire the PCA of your choice.
- ✓ Complaints may be made by writing or calling our offices at the number above.
- ✓ The Agency management or staff will in no way retaliate because you make a complaint.
- ✓ All complaints will be promptly investigated.
- ✓ Timelines for resolving complaints from investigation to resolution typically takes between (30 and 90 days) but could take less or more time depending on the situation.
- ✓ After the investigation is complete you will be notified of the results of your complaint and the investigation in writing.
- ✓ Your complaint with the investigation results will be kept in your file at the Agency.

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John "Jack" Ewert
Hutchinson, MN. 55350

Complaint Intake and Investigation Form

Date received		Intake person	
Type of complaint (what happened)			

Investigation

Date investigated	
Investigator	
Investigation results	
Date of resolution	
Resolution of complaint	
Date of resolution to recipient	

Notes: (Facts, results of investigation, and resolution of complaint including any quality improvement changes, discipline, or instruction)(Attach additional sheets if necessary).

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

PCA Care Plan

Agency: Mommy's Little Girl LLC

Recipient Name:

Recipient:

First:

Middle:

Last:

Address:

Male

Female

Recipient DOB:

City:

State:

Zip:

Service Agreement

Start:

End:

Recipient Phone:

Total Hours Per Day: _____ hrs/day

Shared Services

No

Yes

Recipient email:

The regular PCA(s) shall be (Enter all information)

Responsible Party Name:

1. First:

Last:

First:

Last:

Address:

Email:

Phone:

Address:

2. First:

Last:

Address:

Email:

Email:

Phone:

Phone:

Client History:

EMERGENCY PROCEDURES/HOW TO USE 911

Examples of significant adverse conditions which may necessitate emergency contact and notifying 911 include:

- 1) Has trouble breathing or has stopped breathing; 2) Has no pulse;
- 3) Is bleeding severely; 4) Is in a state of deteriorating unconsciousness or is unconscious;
- 5) If a fracture is suspected; 6) If the person has been badly burned;
- 7) If unable to move one or more limbs; 8) Is having a seizure; 9) Has been poisoned;
- 10) Is having a diabetic emergency; 11) Has suffered a stroke; or
- 12) If there is any doubt as to seriousness of the situation.

HOW TO USE 911

- 1) Dial 911; 2) State: "This is an emergency"; 3) Give the phone number you are calling from;
- 4) Give the address; 5) Describe the problem and how it happened, if known, otherwise just tell the facts and what has been observed;
- 6) Give your name; 7) Stay calm; 8) Reassure the client and family;
- 9) Follow direction of 911 dispatcher; and remember to; 10) Hang up last!

IF YOU DO NOT KNOW HOW TO GIVE CPR

TELL THE DISPATCHER AT ONCE

Backup staffing required?

No (Informal supports used).

Yes (Complete information below)

Contingency Plan - The regular PCA for PCPO recipients shall notify the agency at least 30 minutes prior to any absence. The agency will notify recipient of absences a minimum of 2 hours before an upcoming absence if known. The substitute PCA listed above shall be sent as a backup.

The Backup PCA shall be:

First:

Last:

Phone:

Activities of daily living (ADLs) *Check the applicable boxes below.*

ADL Notes:

Eating

Bathing

Dressing

Grooming

Toileting

Mobility

Positioning

Transfers

Behaviors

Health

Related

Instructions for PCA Help for Health Related Procedures and Tasks:

IADLs Notes

Other living supports (IADLs)

Check the applicable boxes below.

Light Housekeeping

Laundry

Other

*Meal Preparation and Planning

* Medical Appointments

* Shopping

* Accompany to Events and
Outings

Abuse Prevention Plan

What is this person's susceptibility to abuse by other persons including vulnerable adults?

Is this person at risk of abusing other vulnerable adults or self?

What measures shall be taken to minimize the risk of abuse to this person and others?

Additional Notes:

Likes:

Dislikes:

What is most important to client?

What are your care goals for this period?

Were your care plan goals met last period? Scale of 1-10):

January Anticipated Use (Check One) Regularly scheduled use of hours. Increased use of PCA hours. Decreased use of PCA hours.	February Anticipated Use (Check One) Regularly scheduled use of hours. Increased use of PCA hours. Decreased use of PCA hours.
March Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.	April Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.
May Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.	June Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.
July Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.	August Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.
September Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.	October Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.
November Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.	December Anticipated Use (Check One) <input type="checkbox"/> Regularly scheduled use of hours. <input type="checkbox"/> Increased use of PCA hours. <input type="checkbox"/> Decreased use of PCA hours.

Care Plan Signature Page

This care plan was developed for

Name:

DOB:

Service Agreement Date Span:

Available hours:

Shared Care: yes no

Responsible Party:

Responsible Party or Client:

Please sign if you agree to the following terms: I have read and understand the new or updated care plan and agree that this plan was made with myself and the Qualified Professional in person. This care plan is created to provide the best care necessary for myself/the client.

*Please check this box if signing electronically

RP	Date
----	------

PCAs:

Please sign if you agree to the following terms: **I have read and understand the new or updated care plan and agree to follow the clients/RP cares that will help them with common daily activities so that they can be more independent in their homes and communities.**

*Please check this box if signing electronically

PCA	Date
PCA	Date
PCA	Date

Qualified Professional:

Please sign if you agree to the following terms: **I have created this care plan with those applicable present. This care plan was created for the client for help with common daily activities so that they can be more independent in their homes and communities.**

*Please check this box if signing electronically

QP	Date
----	------

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John "Jack" Ewert
Hutchinson, MN. 55350

Qualified Professional Time and Activity Documentation

Recipient name		Date of service	
Date of birth		Subscriber number	
PCA(s)			

Activity with Remarks

PCA employee training and evaluation	€ Completed
Review documentation of services (timesheets)	€ Completed
Develop and review care plan	€ Completed
Review month-to-month plan	€ Completed
Services meeting goals of service plan (if no describe corrective actions)	€ Yes € No
Have the needs of the recipient changed	€ Yes € No
Satisfaction level of recipient (circle one)	Least satisfied [1 2 3 4 5 6 7 8 9 10] Most satisfied

Notes: (Results of evaluation; actions taken to correct deficiency in work of PCA or to address recipient satisfaction)

Time in/out

Time in (Circle AM/PM)	
Time out (Circle AM/PM)	
Total (Minutes)	

Acknowledgement and Signature

Review the completed time sheet for accuracy before signing. Your signature verifies the time and services entered above are accurate and that the services were performed as specified above.

Recipient/ Responsible Party	Qualified Professional
------------------------------	------------------------

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QUALIFIED PROFESSIONAL DOCUMENTATION
(RECIPIENT COPY)

1. Recipient information sheet
2. Care plan
3. Qualified professional time and notes
4. PCA employee evaluations
5. Correspondence

MOMMYS LITTLE GIRL LLC
John "Jack" Ewert
P.O. Box 582
Hutchinson MN. 55350

The who, what and where of mandated reporting

- Hopefully, all people who witness or suspect maltreatment will report the abuse. However, mandated reporters are a special group required to report suspected maltreatment.

- Mandated reporters are professionals identified by law who **MUST** make a report if they have reason to believe that the abuse, neglect, or financial exploitation of a vulnerable adult has occurred. "Mandated reporter" means a professional or professional's delegate while engaged in:

- Social services
- Law enforcement
- Education
- Direct care (this includes all PCAs and Homemakers)
- Licensed health and human services professionals (MS 214.01, subdivision 2)
- Employment in a licensed facility
- Medical examiner or coroner activities

Common Entry Point

- The Common Entry Point (CEP) is a designated unit at the local level that is responsible for receiving reports of suspected maltreatment. The CEP is available 24 hours per day to take calls from mandated and voluntary reporters of suspected maltreatment of vulnerable adults. The CEP will immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

- To report abuse or neglect of a vulnerable adult in Minnesota, contact the local [Common Entry Point \(CEP\)](#) office in the county where the vulnerable adult lives or where the maltreatment occurred.
- The right phone number for each client will be included in their care plan.

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P.O. Box 582
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Definition of maltreatment

Maltreatment means abuse, neglect, or financial exploitation as defined below:

- Abuse** is physical, emotional, or sexual ([MS 656.5572, subd. 2](#))
- Neglect** is the failure to provide for food, clothing, shelter, medical care and/or supervision ([MS 626.5572, subd. 17](#))
- Financial Exploitation** is the misuse of a funds, assets or property or the failure to use the vulnerable adult's financial resources to care for the vulnerable adult, which results in or is likely to result in detriment to the vulnerable adult ([MS 626.5572, subd. 9](#))

Definition of Abuse

- Abuse means an act against a vulnerable adult/minors that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of these statutes:
- Assault in the first through fifth degrees ([MS 609.221](#) to [609.224](#))
- The use of drugs to injure or facilitate crime ([MS 609.235](#))
- The solicitation, inducement, and promotion of prostitution ([MS 609.322](#))
- Criminal sexual conduct in the first through fifth degrees ([MS 609.342](#) to [609.3451](#))

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P.O. Box 582
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Reporting of maltreatment

A **REPORT** means a statement concerning all the circumstances known to the reporter at the time the statement is made surrounding the alleged or suspected maltreatment of a vulnerable adult.

- It starts with a phone call to Mommy's Little Girl LLC or to CEP
- A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately (as soon as possible, but within 24 hours) make an oral report of the information to the Common Entry Point and Mommy's Little Girl LLC.
- Note: Reports from individuals who are deaf, deaf blind or hard of hearing may come through a telecommunications device or through the Minnesota Relay Service and will be considered oral reports.

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John "Jack" Ewert
Hutchinson, MN. 55350

Authorization for Release of Medical Information

Consumer's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Subscriber # _____ Consumer's phone #: _____

I, the above-identified consumer, do hereby authorize the release of my medical records/information to:

Mommy's Little Girl LLC
Name of Provider or Facility

PO BOX 582
Address

Hutchinson, MN. 55350
City, State, Zip Code

Phone # / Fax # Phone 320-583-3799 FAX 612-568-9757

PURPOSE FOR THIS REQUEST: The purpose of this request related my receiving PCA services through the Agency, now or in the future.

TYPE OF RECORDS REQUESTED: I hereby request the release of any and all medical records/information that may reasonably pertain to my future or existing need or receipt of PCA services.

AUTHORIZATION VALID FOR: This authorization is valid for this request and any future services of the kind described herein until I revoke this authorization in writing. This authorization is only valid for the Agency.

I understand that I may revoke this authorization by written request at any time by contacting the facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that my treatment will not be conditioned on my signing of this authorization. A photocopy of this authorization will be treated in the same manner as the original.

Signature of Patient/Responsible Party Date

Signature of Parent Date

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Hutchinson, MN. 55350

PCPO Provider Agreement

Agreement between _____ (hereinafter "Consumer") and The Agency, an enrolled PCA provider with the State of Minnesota.

Consumer Roles and Responsibilities

As a consumer using the Agency, I, or my responsible party, agree to the following responsibilities:

1. Accept responsibility for my health and safety.
2. Ensure that I meet the conditions to use or continue to use a PCA Provider. These include, but are not necessarily limited to:
 - a. I must be able to direct my own care, or my responsible party must be readily available to direct the care provided by the personal care assistant(s).
 - b. I or my responsible party must be knowledgeable of my health care needs and be able to effectively communicate those needs.
 - c. I must ensure that my health insurance coverage is active at all times and I must notify The Agency immediately if there is any lapse in coverage. If fail to do so I am responsible for paying the PCA for the hours worked during the period where there was no coverage or for reimbursing The Agency for payment made for those hours.
 - d. A face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the consumer's condition or change in the need for personal assistant services.
 - e. I must be certain that time sheets submitted by PCAs accurately document the times of service and tasks performed.
3. Abide by all of the consumer responsibilities as set forth in this agreement.
4. Abide by all of the policies for the PCA program.
5. Manage the use of my PCA allocated hours/units to ensure I do not use more than the allocated hours/units in my service plan.
6. Make every effort to manage my PCA schedule to avoid the payment of overtime. If I will need to pay overtime, I will contact the Program Coordinator in advance for approval or alternatives.
7. Monitor, ensure accuracy and verify time worked by my PCAs. Sign verified time cards for my PCA staff.

8. Coordinate with The Agency to notify the county public health nurse, waiver service coordinator or otherwise appropriate individual when it is time for a reassessment of my need for PCA services or if there is a change in condition or change in the level of services that I need. I will inform them of my intent to use The Agency.
9. Notify the Agency of my hospitalization dates throughout our service agreement.

Provider Roles and Responsibilities

As your PCA provider, the Agency agrees to perform the following responsibilities:

1. Enroll and meet all standards as a PCA provider with the Minnesota Department of Human Services, including passing a criminal background check and follow all rules, regulations, and policies described by DHS for the PCA program.
2. Abide by all of the responsibilities set forth in this written agreement.
3. Bill the Minnesota Department of Human Services or appropriate health care plan for personal care assistant and Qualified Professional (if applicable) services rendered.
4. Withhold and remit all applicable state and federal taxes from personal care assistants' and Qualified Professional's paychecks.
5. Arrange for and pay the employer's share of payroll taxes, unemployment insurance, workers' compensation insurance, liability insurance, and bonds for all staff.
6. Keep records of the hours worked by personal care assistants and Qualified Professional.

Regulatory Compliance

Both parties are responsible for complying with all rules and regulations related to PCA. This includes, but is not limited to state Vulnerable Adults Act, Data Privacy, PCA regulations and the Nurse Practices Act, including assistance with medication administration, and Department of Labor laws governing overtime.

Print Name / Signature of Consumer/Responsible party

Date

Print Name / Signature of Parent

Date

The Agency

Date

Recipient Information Sheet

____/____/____
Date

Client's Name

Doctor's Name

Street Address

Street Address

City, State

Zip Code

City, State

Zip Code

Area Code

Phone Number

Area Code

Phone Number

Legal Guardian/Responsible Party

____/____/____
Date of Birth

Age

____ Male

____ Female

Medical Assistance Number

Social Security Number

Other Contact Name & Relationship

Area Code

Phone Number

EMERGENCY CONTACT:

Mommy's Little Girl LLC
FAIR AND ACCURATE BILLING POLICY

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1. Employee shall not work more than **40** (forty) hours in a week without written permission from Jack. If a PCA is working for more than one MLG client he/she must count hours for all MLG clients. Employees may not work more than 12 hours per day or more than 12 continuous hours in any 24 hour span. After 12 hours they must take 8 hours off. If a PCA needs more than 12 they must get written permission from Jack. Employees may not work more than 310 hours per month counting the time with a MLG client and including the time with another Agency's client. If doing over night the Employee shall not be paid when sleeping unless approved by the MLG. MLG's pay period is from Sunday to Saturday. MLG does not pay Holiday Pay.
2. Employees may only submit time cards that reflect hours actually worked and use time cards provided by the Agency;
3. Employees will only be paid for time cards that are signed by the recipient or responsible party;
4. No employee shall be paid for time where the recipient is in a hospital, nursing home, or other out of home placement, all PCA time must be in the recipient home or where normal activities in the community. No PCA time may be done in the PCA's home unless the Client lives with the PCA. A PCA may not do home maintenance or chore services. A PCA may accompany parent(s) and recipient under 18 to medical appointments. PCA is not allowed to care for other adults or children while doing PCA time. Recipients under 18 do not get IADL's unless in the PHN assessment.
5. Any payments made to an employee for time submitted while a recipient is in a hospital, nursing home, or other out of home placement facility shall be treated as overpayments and shall be recovered from the employee per State and/or Federal law.
6. Any payments made to an employee where it is later determined that the employee submitted time in excess of 12 hours per day or 310 hours per month shall be treated as overpayments and shall be recovered from the employee in per State and/or Federal law.
7. The Agency shall notify recipient/responsible party when there is a gap in a recipient's health insurance. Recipient/responsible party must inform pca of the gap and be responsible for payment to pca.
8. No employee shall be paid for time where there is a gap in a recipient's health insurance coverage without the written permission of the Agency.
9. Any payments made to an employee for time submitted after a recipient has exhausted his or her PCA approved units shall be treated as overpayments and shall be recovered from the employee in accordance with State and/or Federal law.
10. Employees may only begin providing services after receiving the express permission of the Agency in writing. Recipients may not alter the decision of the Agency regarding any employee's start date. No employee shall be paid for services provided without the express written permission of the Agency.
11. Employees may not work more hours per day than a recipient is authorized to receive without the express written permission of the recipient or the Agency.
12. The Agency shall notify employees when a recipient has exhausted their PCA approved units.
13. No employee shall be paid for time where the recipient has exhausted his or her PCA approved units.
14. Any payments made to an employee for time submitted after a recipient has exhausted his or her PCA approved units shall be treated as overpayments and shall be recovered from the employee in accordance with State and/or Federal law.

15. Time sheets should be mailed by the following Monday. Checks will be mailed every other Wednesday, for those picking up checks they will be put in the mail box by 4:00 P.M.
16. There will be a charge of \$5.00 for reprint of paystubs with a minimum charge of \$20.00.
17. Failure to cooperate with the scheduled RN supervision visits will result in NO PCA time allowed until the visit is done. The Care Plan should be done within 7 days at the Clients home with the PCAs at the start of a new service agreement. Follow up visits need to be done every 120 days. A new client must be done every 90 days the first year.
18. Failure to turn in time sheets on time, return phone calls, text messages, emails or letters in a timely fashion will result in a pay reduction to the PCA.
19. Mommy's Little Girl allows the PCA to work for any recipient or any agency once they leave as a PCA for Mommy's Little Girl. Mommy's Little Girl will not take any action preventing the PCA from doing this regardless of any prior agreements.
20. If a Client's status becomes ineligible, or inactive per the DHS web site; MLG shall notify the Client/Responsible Party. Generally, the status will become ineligible or inactive due to Client/Responsible Party not turning in paperwork in a timely fashion. MLG will NOT be responsible for paying the PCA but it will be the responsibility of the Client and or Responsible Party to pay the PCA. It is importance for the Client/Responsible Party to stay current with their paperwork. Generally, the status will go retroactive to the first of the month if the paperwork is completed and then MLG can pay the PCA.
21. By signing the time sheet as a Responsible Party for the Recipient you agree to the following responsibilities;

- 1 Attend assessments for PCA services for the recipient to help the recipient make informed choices.
- 2 Determine if the recipient's health and safety are assured with the current PCA services.
- 3 Help develop the PCA care plan with the qualified professional.
- 4 Actively participate in planning and direction of PCA services.
- 5 Sign the PCA time sheets after services are provided to verify the services.
- 6 Monitor the PCA weekly to ensure the care plan is followed and the care outcomes are met as describe below.
- 7 Be assessable to the recipient and PCA when services are provided as described below.

A Responsible Party must be (1) at least 18 years of age, (2) not the owner or manager of the PCA provider agency, (3) not a personal care assistant for this recipient, (4) not the qualified

22. I have read, signed and initialed the 11 activities that the DHS DOES NOT allow a PCA to do. TRANSPORTATION OF RECIPIENTS; MLG's company policy regarding transportation is
 23. that PCAs should not transport clients in personal vehicles for insurance liability reasons. PCAs should contact their personal insurance agent. MLG is not liable for any loss, damage, costs or expenses incurred by clients or PCAs due to MLG PCAs transporting clients or by PCAs traveling in client vehicles. Alternative transportation should be taken. Some options are Trailblazer Transit, Public Transportation, Private Taxi Service.
 24. MLG has the Department of Labor's Sick and Safe Time (ESST) on our website and has been email to each PCA. The PCA should read the ESST policy to know what is expected of MLG and the PCA.
 25. MLG requires the PCA to use the EVV time sheets with the Care Tap EVV system.
- Note: It is a federal crime to provide false information on PCA billings for Medical Assistance Payment. Providing false information on PCA billings may also result in your termination.

Print Name _____ Sign _____ Date _____

Mommy's Little Girl LLC

FAIR AND ACCURATE BILLING POLICY - Addendum

PCA Services Not Allowed by the DHS

January 1, 2024

The DHS **DOES NOT ALLOW** a PCA to do the following; Please **initial next to each one and sign and date below.**

- _____ 1: No PCA time may be done when the recipient is in a hospital, nursing home, or other out of home placement.
- _____ 2: A PCA may not do home maintenance or chore services.
- _____ 3: A PCA may accompany parent(s) and recipient under 18 to medical appointments.
- _____ 4: PCA is not allowed to care for other adults or children while doing PCA time.
- _____ 5: Recipients under 18 do not get IADL's unless in the PHN assessment.
- _____ 6: A PCA cannot do services that are not in the Assessment or Care Plan.
- _____ 7: A PCA may not provide services if they are a legal guardian, responsible party, person's spouse, or a parent of a minor child.
- _____ 8: A PCA cannot use restraints with a client.
- _____ 9: Perform sterile procedures or administer medications.
- _____ 10: A PCA cannot do Injections of fluid and medications into veins, muscles or skin.

RP Print Name _____ Sign _____ Date _____

MOMMYS LITTLE GIRL LLC
P.O. Box 582
Hutchinson, MN. 55350
John "Jack" Ewert
Phone 320-583-3799
Fax 612-568-9757
Email jewert@hutchtel.net

ACKNOWLEDGEMENT OF RECEIPT MATERIALS

I acknowledge that I received a copy of the following:

1. Home care bill of rights;
2. Advance directive notice;
3. Spend-down notice and policy;
4. Complaint procedure;
5. Care plan (to be developed with the assistance of qualified professional);
6. Authorization for release of medical information (to be completed and returned to our office, 1 page).
7. PCPO Provider Agreement (to be completed and returned to our office – 2 pages)
8. Fair and accurate billing policy Edit 33 January 1,2024 (to be completed and returned to our office, 2 pages).
9. Addendum to Fair and Accurate Billing – PCA Service Not Allowed. January 1, 2024. (To be completed and returned to our office, 1 page)
10. Recipient information sheet (to be completed and returned to our office, 1 page)
11. The who, what and where of mandated reporting
12. Definition of maltreatment
13. Reporting of maltreatment

Print Name	Signature of Client or Responsible Party	Date
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Print Name	Signature of Parent	Date
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