COMMUNITY CHOICES WAIVER
EMPLOYER OF RECORD DESIGNATION AND POWER OF ATTORNEY FOR PARTICIPANT DIRECTION

IMPORTANT INFORMATION

The Community Choices Waiver (CCW) offers you as a participant of the CCW program, or your legal representative, 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 to 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 grant power of attorney and authorize 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.

Unless you specify otherwise, the EOR's authority will generally continue until services end, the power of attorney is revoked, or until the EOR resigns or is unable to act for you. This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

This power of attorney does not authorize the EOR to make other financial or healthcare decisions on your behalf. If you have questions about the power of attorney or 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 granting a power of attorney 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 power of attorney does not eliminate the possibility of penalties under applicable state and federal law for fraudulent, false, or misleading claims.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____

_____

_____

_____

_____

_____

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_____

_____

EFFECTIVE DATE

This limited EOR power of attorney 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:

**This form must be signed by the Community Choices Waiver participant or by his/her guardian or legal representative when decision-making authority has been conferred to someone other than the participant. Documentation of guardianship or legal representation required.*

IMPORTANT INFORMATION FOR EMPLOYER OF RECORD

EOR DUTIES

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the participant. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You shall:

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.

TERMINATION OF EOR AUTHORITY

You shall stop acting on behalf of the participant if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

1. Death of the participant;
2. The participant's revocation of the power of attorney or your authority;
3. The occurrence of a termination event stated in the Special Instructions;
4. The purpose of the power of attorney is fully accomplished;
5. Termination of the participant’s participant-directed services;

6. You no longer meet the Community Choices Waiver program criteria to serve as a designated employer of record; or
7. If you are married to the participant, and there is a legal separation or termination of the marriage.

EOR LIABILITY

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act, W.S. 3-9-101 through 3-9-403. If you violate the Uniform Power of Attorney Act, W.S. 3-9-101 through 3-9-403, or act outside the authority granted, you may be liable for any damages caused by your violation. If there is anything about this document or your duties that you do not understand, you should seek legal advice.

You may personally be held responsible under applicable state and federal laws for any fraudulent, false, or misleading medical assistance claim that you make, use, present, or cause to be made, used, or presented to Wyoming Medicaid.

EOR CERTIFICATION AS TO THE VALIDITY OF POWER OF ATTORNEY AND EOR AUTHORITY

I,_____(Name of EOR), certify under penalty of perjury that

_____(Name of Participant) granted me authority as an

EOR in a power of attorney dated _____.

I further certify that, to my knowledge:

1. The participant is alive and has not revoked the power of attorney or my authority to act under the power of attorney and the power of attorney and my authority to act under the power of attorney have not terminated; and
2. If the power of attorney was drafted to become effective upon the happening of an event or contingency, the event or contingency has occurred.

SIGNATURE AND ACKNOWLEDGMENT

_____

EOR Signature and Date:

_____

EOR Name Printed: