HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

PARTICIPANT DIRECTION EMPLOYER DELEGATION

To be completed by the Participant or Participant's legal representative ONLY if the PD Employer role is being delegated to someone other than the Participant or Participant's legal representative.

The Home and Community Based Services (HCBS) Program offers you, as the participant*, the opportunity to take an active role in the management of select services through the participant-directed service delivery option. You may choose to direct your own services or assign another person you trust to serve as the designated Participant-Directed Employer (PD Employer) and direct services on your behalf.

In order to choose another individual as PD Employer, which will allow them to make decisions on your behalf about the employer-related duties and responsibilities, you must confirm that you want that person to take on the responsibilities described below by completing this form.

Your delegate PD Employer is authorized to act on your behalf only as it relates to the employment functions outlined below, and cannot make other financial or healthcare decisions on your behalf as part of this documented authorization. If you have questions about the authority you are granting to your PD Employer, you should seek legal advice before signing this form.

IMPORTANT INFORMATION:

Throughout this document, "participant*" is used to indicate either the participant or the person who is charged with making legally binding decisions on the participant's behalf - such as their guardian, parent, or other court-designated decision maker. If you as the participant, or your legal representative as described above, are accepting the role of PD Employer **this form does not need to be completed. Instead, you will fill out and submit the PD Employer Agreement.*

If the participant has a legal representative as described AND the PD Employer responsibilities are being delegated to another individual, the legal representative must sign this form where "Participant" is indicated, and present documentation of guardianship or legal representative/decision maker authority to the Case Manager.*

EMPLOYER AUTHORITY COMPLIANCE:

The Participant-Directed Employer is tasked with conducting these employment-related functions as it relates to employing individuals to provide services to the participant through the participant-directed service delivery option:

1. Create a job description for each employee;
2. Recruit, select, and hire employees to provide participant-directed services;
3. Verify that minimum employee qualifications are met, as required by the waiver program;
4. Ensure each employee has completed enrollment for Financial Management Service (FMS) and required approvals have been received before the employee begins providing services;
5. Ensure all employees receive and maintain the program-required certifications and complete required trainings, and recertification, and retraining, throughout their employment;
6. Determine and communicate any additional qualifications, certifications, or trainings employees must have in place prior to providing services to the participant;
7. Set employee wages within the Agency-set limits, and program guidelines;
8. Define employee duties in alignment with the corresponding Waiver Service Index and within the limits of the program;
9. Orient, train, and instruct employees in their duties;

10. Supervise, evaluate, and manage employees and their performance;
11. Schedule and manage service delivery to ensure the participant can receive appropriate services throughout their plan of care period, without exceeding the Agency approved participant-directed budget;
12. Verify service delivery and time worked for each employee by reviewing and approving employee shifts/visits or timesheets within the FMS online portal or mobile application prior to submitting for processing of payroll;
13. Discipline, discharge, or terminate employees, as warranted.

PARTICIPANT* DELEGATION OF EMPLOYER ROLE:

I understand that delegating these duties to someone else does not limit or discharge my responsibility or liability for truthfulness, completeness, and accuracy of all claims and information 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.

DESIGNATION OF EMPLOYER

I, _____, *(Participant* first and last name)* designate the following person to act in the role of PD Employer on my behalf, in order to conduct the employment-related duties outlined above:

Name of Delegate PD Employer: _____

Delegate PD Employer Email: _____

Delegate PD Employer Telephone: _____

Delegate PD Employer Mailing Address: _____

Participant's* Signature: _____ **Date:** _____

If the participant's authorized representative is completing this form, please sign your name above, and print the Participant's first and last name below.

Participant's First and Last Name: _____