Memorandum of Understanding for the Administration and Co-Management of Community Habilitation Self/Family-Directed Option

This agreement is based on the understanding that _____
(Name of Individual)
is and remains eligible for Community Habilitation (CH) services. By choosing the self-directed/family directed option, the individual/individual's family and the Provider Agency agree to co-manage the Community Habilitation self/family-directed (CH/SD) services as partners. In self-directed and family-directed services, the **Manager of Services** is either the individual or his/her identified adult. For clarification, please refer to **Regulation 635-10.5** (ab)(11). In both cases, the Agency will function as the **Employer of Record.**

☐ **This plan is self-directed by**_____
(Name of Individual/Identified Adult)

☐ **This plan is family-directed by:**
_____ **on behalf of**_____
(Name of Parent/Guardian/Identified Adult) (Individual's Name)

The Manager of Services agrees to the following responsibilities:

- I will work cooperatively with the Employer of Record to hire, train, and oversee staff selected to provide these services. I understand that I may recommend people that I know for consideration as possible staff, but that the Employer of Record will make the final decision to hire someone based on the Agency's employment requirements and the results of the person's background check.

- I understand that staff I select who are hired by the Employer of Record, are assigned specifically to assist _____with CH/SD.
(Name of Individual)

- As the Manager of Services, I will oversee the staff's schedule and keep the Employer of Record informed of the schedule.

- I will choose which habilitation activities in the CH Plan that the staff will work on each day.

- I am responsible for maintaining my Medicaid eligibility or the Medicaid eligibility for _____.
(Name of Individual)

- I understand that CH/SD services will be paid for with public funds based on the service documentation that staff must complete. I also understand that staff must comply with all of the provider's requirements for Medicaid documentation and accountability. I will immediately inform the agency if I am aware of problems with the service documentation.

- I will let the Employer of Record know about any special training I think the staff need. If possible, I will also help to train the staff in these areas.

- If I am not happy with the staff's work, I will discuss my concerns with the Employer of Record and try to resolve the issues. I understand that any decision to terminate a staff's employment will be made by the Employer of Record in compliance with agency rules, but I may decide whether or not to work with a specific staff person.

- If I decide to discontinue this agreement, I will notify the Employer of Record at least 30 days in advance, as indicated in the "Discontinuation Process."

The Agency, as Employer of Record, agrees to the following responsibilities:

- We will consider people recommended by the Manager of Services as potential staff and assure that all staff will meet our requirements of employment, including background checks. We retain responsibility for making the final decision on whether or not a person meets the requirements to be hired as a staff. We will honor any decision on the part of the Manager to no longer work with an employee. We retain the right to make the final decision regarding termination or reassignment from employment.

- If we are not satisfied with a staff's performance, we will discuss our concerns with the Manager of Services and try to resolve the issues. Any decision to terminate a staff's employment will be made by the Employer of Record in compliance with Agency rules and procedures.

- We will provide and facilitate the training required by regulation and our agency's personnel procedures, as well as any additional training we find necessary or appropriate to meet the individual's needs. If the Manager of Services identifies additional training specific to the individual's needs, we will make every effort to assist with providing the training if requested to do so.

- We have responsibility for all payroll and personnel activities.

- We will review the service documentation that is completed by staff to ensure that the services are consistent with the individual's CH Plan. We will submit claims for payment based on this documentation.

- We will maintain a record of service hours and report the rate of usage to the Manager of Service at least quarterly.

- If we, as the Employer of Record, find it necessary to discontinue this MOU as indicated below in the "CH/SD Discontinuation Process", we will notify the individual/family at least 30 days in advance. We will also be responsible for notifying the individual's MSC and the DDSO CH Liaisons at least 30 days in advance; and we will continue to be party to this agreement until the 30 day period is completed or until alternative arrangements begin, whichever is sooner.

The Provider Agency and/or the Individual/Individual's Family, as Managers of the CH Self-Directed/Family-Directed service, have read and agreed to the responsibilities outlined in this MOU.

Signed:

Manager of Services_____ Date_____
(Individual/Identified Adult)

Employer of Record_____ Date_____
(Agency Representative)

COMMUNITY HABILITATION SELF/FAMILY DIRECTED DISCONTINUATION PROCESS

Either party may choose to discontinue this agreement as long as written notification of the intent to discontinue is provided to the other party in a manner that is consistent with this MOU. It is not necessary to complete this form if you are only changing or terminating a CH/SD staff person.

ANTICIPATED LAST DATE OF THIS AGREEMENT: ____/____/____.

Please identify below:

- ☐ As Manager of Services, I wish to discontinue this CH/Self/Family Directed agreement. This discontinuation does not negate my eligibility to continue participation in the Community Habilitation /Direct Support service offered by the Employer of Record.

- ☐ As Employer of Record, we wish to discontinue this CH/Self/Family Directed agreement. We will continue to participate in this agreement for the management of _____ 's CH services for 30 days or until an alternate arrangement
  (Name of Individual)
  is made, whichever is earlier.

Upon discontinuation of the CH/SD agreement, the OPWDD may conduct an exit interview with the person and/or his or her identified adult using a statewide protocol.

This document must be signed by the party who initiates the CH/SD discontinuation process as indicated above.

Signed:

Manager of Service _____Date_____
(Individual **or** Parent/Guardian/Identified Adult)

Employer of Record_____Date_____
(Agency Representative)