Georgia
ICWP
Employee Agreement

Name of Member (please print) _____
Member Name

Name of Employee (please print) _____
Employee Name

Employee Address _____
Number Street Unit/Apt

_____
City State Zip

Employee Phone _____ **Employee Email** _____
Phone Number Email Address

The employee agrees to accept payment for services provided for individuals served through the Independent Care Waiver Services (ICWP) Program through the Georgia Department of Community Health (DCH). Fiscal management services are provided by Acumen Fiscal Agent, LLC (Acumen), which is not a Georgia government agency. Acceptance and endorsement of payment will signify that the employee agrees to the following terms and conditions:

1. I understand and acknowledge that the ICWP member or their representative is my employer. My employer is not Acumen, DCH or any other entity involved with this Consumer Directed Care option.

2. I accept payment from Acumen as payment in full for the services provided. I cannot accept any additional compensation for the hours I have worked.

3. I acknowledge that I am at least 18 years of age.

4. I agree to complete and keep current the required training and certifications as specified in Part I and the applicable Part II manuals, including but not limited to First Aid and CPR certifications. I understand that the certifications must be updated and submitted to the employer on an annual basis in order to remain in compliance.

5. I will provide only the services that have been approved by my employer and authorized in the member's Plan of Care (POC) and Individual Budget and in compliance with the rules of the Consumer Directed Care option.

6. I understand and acknowledge that any hours worked in excess of 40 hours per week will be paid at straight time.

7. I understand and acknowledge that work performed in excess of the authorized amount, service limits or hours will not be paid by DCH nor Acumen Fiscal Agent.

8. I will provide DCH or its designee information regarding the service(s) provided for which payment was made, upon request.

9. I recognize that employment is dependent on the member's participation in the ICWP, Consumer Directed Care option.

10. I will immediately notify a person designated by the employer of any member medical emergency, illness, or visit to a physician.

11. I will take part in any meetings if requested by and/or regarding the member.

12. I understand and consent to having a criminal background records check performed by Acumen. I understand my employment is contingent upon the results of these checks complying with all applicable laws, rules and policies.

13. I understand that the results of my background checks will be made available to my prospective employer and other program staff as necessary and/or required.

14. I agree to complete all required paperwork and be approved prior to providing service(s) requested under this consumer-directed program.

15. I understand and acknowledge that any untruthful submission of services provided in an attempt to obtain improper payment is subject to investigation as Medicaid Fraud. I understand that Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.

16. I agree to protect the confidentiality of personal and health information relating to the member. I agree to release that information only on the request of the member or as otherwise allowed by law.

By signing below, I acknowledge that I have read this employee agreement in its entirety (2 pages). I understand that I must sign and return both pages as a condition of employment in this program and that I cannot begin working in the Independent Care Waiver Services Program (ICWP) Consumer-Directed Care option until this form is completed and returned to Acumen Fiscal Agent. I further acknowledge by signing below, that I understand what is being required of me, and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and/or conditions of this agreement may result in termination of this agreement and payment for employment by any Medicaid Recipient participating in this program.

Employee signature Date

Employer signature Date