

PRIOR WORK EXPERIENCE

<u>COMPANY NAME</u>	<u>ADDRESS</u>	<u>SUPERVISOR</u>	<u>POSITION</u>	<u>PHONE NUMBER</u>

PERSONAL REFERENCES

<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE NUMBER</u>

PROVIDER QUALIFICATION:

PLEASE LIST ANY SPECIAL TRAINING, SKILLS, OR CERTIFICATIONS YOU HOLD THAT WOULD PERTAIN TO THE POSITION YOU ARE APPLYING FOR BELOW:

Have you ever been convicted of a felony involving forgery, robbery, larceny, fraud, cruelty to persons, sexual assault, assault, assault of an elderly, blind, disabled, pregnant or mentally retarded person or abuse of the elderly, blind, disabled or mentally retarded person in the United States and/or it's territories? Yes No

LANGUAGES SPOKEN (CHECK THOSE THAT APPLY):

ENGLISH SPANISH OTHER (LIST): _____

Are you currently a provider on the ABI Medicaid Waiver Program (check one): Yes No

If you checked no, would you like information to be sent to you regarding this program (check one): Yes No

*The ABI Medicaid Waiver Program is a home & community based program for those individuals who have sustained an acquired brain injury and allows the individual to live in their home or community with supports. Providers for this program are needed in all areas of the State. Individuals whom are listed on the directory for this program may receive telephone calls from the participants on the program, their DSS social worker, conservator, or family representative looking for individuals to provide services to them.

Please check here if you are currently employed by another individual on the P.C.A. Waiver, ABI Waiver, or CT Home Care Program for Elders:

By signing and dating below, I understand that a Criminal Background check will be performed prior to being hired by an individual on the PCA Waiver Program or at the request of my potential employer. I also authorize full release of information from my listed employers and references.

Provider Name: *(please print)* _____

Provider Signature: _____ Date Signed: _____



P.C.A. WAIVER / C.H.C.P.E. PROVIDER AGREEMENT

Please read the below statements and fill in the wage per hour that you and your employer have agreed upon. After reading the information please PRINT your name, sign your name, and date the form. These areas must be completed in order for the application to be processed. If you are currently not working for an individual and just wish to have your name added to our directory, you may leave the employer name and wage portion of the form blank at this time. You will be required to complete this portion when you are hired by a participant on the program.

- 1. All of the statements made by me on this application and all information contained in my supporting provider qualification documentation are true and correct.
2. I acknowledge that I can perform all the standards and duties for the service I am applying for.
3. I will immediately notify the Department and the Fiduciary Agent if any information provided by me on this application changes.
4. I will provide (EXCEPT while the participant is in a hospital/skilled nursing facility), service in accordance with the terms of the Participant's service plan.
5. The rate paid by the department for the performance of PCA services is the complete payment in full for all services delivered to eligible P.C.A. Waiver and CT Home Care Program for Elders (CHCPE) participants.
6. Except for authorized co-payments made by eligible participants, the Departments payments to me for the performance of PCA services constitute sole and complete payment in full.
7. I will maintain records that fully disclose the services rendered and/or delivered to the authorized participants. These records will be made available to authorized representatives of the Departments upon request.
8. I acknowledge that I am 16 years of age or older and eligible to provide services under the P.C.A. Waiver Program.
9. I acknowledge that I am 18 years of age or older and eligible to provide services under CT Home Care Program for Elders.
10. I agree to not use or disclose protected health information (PHI) other than as permitted or as required by law and to use appropriate safeguards to prevent improper use or disclosure of PHI.
11. I acknowledge that I may be suspended or terminated from the Provider Directory if I am found by the Department of Social Services to have engaged in fraudulent or abusive program services.
12. This is a State and Federal Government Program. Altering timesheets, hours, or reporting of false hours is considered fraud. You will be subject to prosecution for fraud to the fullest extent of the law. You may be subject to prosecution on both a State and Federal level should you commit this crime.
13. I understand that this program does not provide Worker's Compensation Coverage for its employees. However, my employer may acquire Worker's Compensation insurance on their own.
14. I understand that I am NOT employed by Allied Community Resources. Allied Community Resources is a Fiduciary Agent on behalf of the client that I am employed by and only distributes my payroll.
15. I have been hired by (print Employer name) at an HOURLY RATE of PAY** of \$ PER HOUR (before my employee taxes are deducted) AND I understand that I may not work more than 25.75 hours per week for this Employer unless my employer obtains and maintains Worker's Compensation Insurance.
16. By signing this agreement I consent to have a Criminal Background Check performed PRIOR to actual employment by any prospective employer, his/her authorized designated representative, and/or the State of Connecticut.
17. I have read and accept the terms of this Provider Agreement as stated to me above and I also understand that employment may be contingent upon the results of the Criminal Background Check as well as my inclusion on the state-wide provider directory.

PROVIDER NAME (please print name)

SIGNATURE (must sign)

DATE SIGNED

**SUBJECT TO CHANGE BASED UPON PROGRAM PROVISIONS