Parents as Paid Caregivers Service Model Acknowledgment of Understanding and Agreement to Follow Service Model Requirements

Member Name _____ AHCCCS ID # _____

General Instructions Regarding This Form:

1. The form shall be reviewed, completed and signed after a decision has been made regarding the election of the Parents as Paid Caregivers (PPCG) service model as a result of the use of the "Minor Caregiver Options: Discussion Guide and Decision Roadmap" tool. This conversation and election will occur during the annual Person-Centered Service Plan (PCSP) or a 90-day review meeting.

2. The Support Coordinator shall provide a copy of the completed and signed form to the provider agency selected to provide the member's care after the parent has agreed to be employed or contracted by the agency. The parent shall also be provided with a copy for their records.

3. There must be one of these forms completed for each parent, when multiple parents are supporting the same child. In the context of PPCG, a parent has formal and/or legal custody of a minor child. This includes biological/adoptive parents and guardians of minor children.

4. The parent must acknowledge each statement by signing their initials next to the statement. It is permissible for a parent to indicate "Not applicable or N/A" for those statements that are specific to the EPD/DDD program and don't apply because their child is not a member of that program.

5. The parent must complete and sign the form to get paid to provide care and participate in the program.

6. The parent should seek clarification from the provider agency, the Support Coordinator or the resources noted, as appropriate, prior to initialing statements and signing the bottom of the form.

7. The form shall be signed by the parent and Support Coordinator.

8. A copy of the completed form shall be retained as an exhibit to the member's PCSP.

See page 5 for EOE/ADA disclosures

Member Name _____ AHCCCS ID # _____

Statement	Initials
1. I attest that I have been a resident of the State of Arizona since _____ Insert Date: Month, Day, Year I understand that I am required to be an Arizona resident for at least six months before I receive pay to provide authorized services to my minor child as per ARS 36-3312. A resident of Arizona is defined as a person living within the State of Arizona with or without a fixed address. I understand I may be asked at any time to provide proof of residency that confirms the date I provided above. Failure to comply with this requirement may result in a fraud referral to the Office of Inspector General and/or the Attorney General's Office.	
2. I understand the total number of service hours assessed for my child are medically necessary and qualify as extraordinary care as determined through the service planning process.	
3. I voluntarily agree to provide paid care that is consistent with my child's PCSP.	
4. To promote age-appropriate socialization, I agree to support the individualized goal(s) in the PCSP focused on my child engaging with other children in the community.	
5. I understand that I will either be employed or contracted by the service provider agency and must comply with any standard employee/contractor requirements including service provider agency specific requirements.	
6. I understand that before I can provide paid care, I must meet all qualifications including:	
a. Be at least 18 years old or meet the age requirement determined by the service provider agency,	
b. Have or be able to obtain the following documentation:	
I. Evidence of being trained in Article 9 if my child is a DDD member,	
II. Evidence of being trained in CPR/First Aid, and	
III. Evidence of completing Direct Care Worker (DCW) Training, as directed by the service provider agency.	
c. Have evidence of being trained in the delivery of habilitation services as directed by the service provider agency, and	
d. Pass background checks, including checks of the Department of Child Safety (DCS) Central Registry and the Adult Protective Services (APS) Registry.	

Member Name _____ AHCCCS ID # _____

Statement	Initials
7. If my child is a member of DDD, I understand the following regarding Level 1 fingerprint clearance per ARS 36-594.01:	
a. If I am only providing attendant care and I reside in the same home as my child, I DO NOT have to obtain a Level 1 fingerprint clearance card,	
b. If I am only providing attendant care and I DO NOT reside in the same home as my child, I DO have to obtain a Level 1 fingerprint clearance card, and/or	
c. If I am providing habilitation, I DO have to obtain a Level 1 fingerprint clearance card.	
8. If my child is an ALTCS EPD or Tribal ALTCS member, I understand that per the AMPM Policy 1240-A and AMPM Policy 1240-E, I am required to pass a criminal background check.	
9. I understand I have to comply with continuing education requirements as directed by the service provider agency.	
10. I understand that I cannot work and be paid by another employer during the hours I am providing paid care for my child.	
11. I understand that when I am providing paid care to meet my child's assessed needs, I am not to participate in personal or familial responsibilities that hinder the quality and continuity of my child's care needs being met as outlined in the PCSP (i.e., running errands, volunteering, caring for other children or family members).	
12. If my child is an ALTCS member of DES/DDD, I understand the requirements of administrative rules A.A.C. 6-6-901 through 6-6-910 must be met during all the times I am being paid for care by a service provider agency. "Time-outs", withholding access to basic needs such as food (e.g., "no dinner until after your room is clean"), and corporal punishment such as "spanking" are examples of techniques a parent may not use while getting paid to provide attendant care and/or habilitation services.	
13. I agree to follow my service provider agency's procedures for notifying the agency if I am no longer able to provide paid care on a permanent or temporary basis and an alternative caregiver is needed. This includes situations where I may need to reduce the number of hours I am getting paid to provide care. After notifying the agency, I shall also share this information with my child's Support Coordinator.	
14. I understand the service provider agency will develop a contingency plan with me to ensure my child receives care if there is an unforeseen situation where I am unable to provide the services. If there is an unforeseen circumstance that prohibits me from being able to provide paid care on a particular day, I will contact the service provider agency as soon as I am aware of this situation to implement the contingency plan.	
15. I understand that if my child is assessed as needing more than 40 hours of paid care (i.e., attendant care and habilitation) in a seven-day period a non-parent caregiver must be recruited by a service provider agency to provide any care for over 40 hours.	

Member Name _____ AHCCCS ID # _____

Statement	Initials
16. I agree to share my child and family preferences with the provider agency to support the agency's recruitment of competent caregivers to serve my child including alternate caregivers for when I am unable to provide the paid care and/or caregivers to provide respite services. I understand that I have the opportunity to participate in the recruitment of caregivers along with the service provider agency if I choose to do so; however, I am not obligated to do this if I do not want to.	
17. I understand that I am limited in the paid care I can provide and these limitations will be monitored by both my service provider agency and my child's health plan:	
a. I shall not provide more than 40 hours of paid care (i.e. attendant care or habilitation) in a seven-day period. The service provider agency will monitor my compliance based upon their identified work week,	
b. If another parent and I are providing paid care to our child, the combined hours between both parents cannot exceed 40 hours of paid care in a seven-day period for that child regardless of how the hours are split between multiple service provider agencies,	
c. I may not provide more than 16 hours of paid care in a 24-hour period to any combination of DDD members and any combination of services (e.g. one member participating in PPCG, 2+ children participating in PPCG, other non-PPCG participating members),	
d. I shall be employed/contracted by one agency for services I provide to my child(ren) per ARS 36-2970.02,	
e. I shall not receive pay for services when my child is not present per ARS 36-2970.01,	
f. I shall not receive pay for services when my child is receiving care from a licensed provider or at a licensed outpatient or inpatient facility per ARS 36-2970.01,	
g. I shall not receive pay for services and tasks that are not assessed and authorized in accordance with the HCBS Needs Tool including services provided during overnight hours ARS 36-2970.02,	
h. I understand I shall not receive pay for services while my child is engaging in, participating in, or receiving privately or publicly funded K-12 educational services, programs or grants, and	
i. I understand if my child and I are going to be traveling and services are needed, I must notify the Support Coordinator and follow the health plan's policies for covered services when provided outside the health plan's service area.	
18. I agree to comply with Electronic Visit Verification (EVV) requirements and any other documentation requirements as directed by the service provider agency (i.e., progress notes for habilitation services). If I have questions about EVV I will ask my service provider agency.	
19. I agree to comply with supervisory visits from my service provider agency.	
20. I agree to comply with 90-day visitation in my home by my child's Support Coordinator.	

Member Name _____ AHCCCS ID # _____

Statement	Initials
21. I agree to follow my service provider agency's policies on reporting critical incidents (e.g., abuse, neglect, exploitation, injury).	
22. I understand that any earned income as a paid caregiver may have an impact on AHCCCS eligibility for myself or the rest of the household. Income I receive for providing attendant care or habilitation services may qualify as "difficulty of care" payments that may be excluded wages for Medicaid eligibility when certain criteria are met. Contact AHCCCS by phone (602-417-5010 or 1-800-528-0142) or email (dmps.sos@azahcccs.gov) with any questions about your wages and eligibility.	
23. I understand the extra income could have an impact on other publicly funded benefits either myself or my family are receiving (e.g., SNAP, housing). It is recommended to contact your benefit providers to learn more.	
24. I understand that I may voluntarily share with the service provider agency or my Support Coordinator if I or my family unit may benefit from resources to help support providing paid care (e.g. resources to help focus on my health and wellbeing or for training needs).	

By signing this form, I acknowledge that I understand and agree to comply with the requirements. If I am found to be non-compliant with any of these requirements that I have acknowledged/initialed above, I may lose my ability to participate in the Parents as Paid Caregiver service model. I also understand that, at any time, I can change my mind about participating by telling my child's Support Coordinator and the provider agency to discuss and arrange for alternate caregivers.

Signature of Parent: _____ Date _____

Printed Parent Name: _____

Signature of Support Coordinator: _____ Date _____