Independent Living
RESOURCE CENTER

3033 WEST 2ND STREET NORTH
WICHITA • KANSAS • 67203
TELEPHONE/TTY 316 • 942 • 6300

NEW CUSTOMER
FINACIAL MANAGEMENT SERVICES (FMS)
SELF-DIRECT PAPERWORK

HCBS Customer, [redacted] **Waiver:** [redacted]

THIS PAPERWORK MUST BE COMPLETED AND SUBMITTED TO OUR OFFICE BEFORE YOU CAN HIRE ANY DIRECT SUPPORT WORKERS (caregivers), THIS PAPERWORK IS THE AGREEMENTS BETWEEN "YOU" THE CUSTOMER (employer) AND ILRC AS FISCAL AGENT TO PROVIDE PAYROLL SERVICES FOR YOUR HCBS SELF DIRECT CARE.

Follow item 1 to 6 below, READ THE PAPERWORK before you fill it out these are legal documents.

1. [redacted] THE "ORANGE" AREAS ARE FOR YOU TO FILL OUT AS THE CUSTOMER (employer).
2. WE ASK THAT YOU PROVIDE A COPY OF YOUR INSURANCE CARD(S) FOR US TO KEEP ON FILE FOR THIRD PARTY BILLING PURPOSES ONLY.
3. **RETURN THE CIRCLED ITEMS ONLY:** (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) **REGARDLESS, IF A SIGNATURE IS REQUIRED ON THE PAGE.**
4. MAKE A COPY OF THIS PAPERWORK FOR YOUR RECORDS.
5. PLEASE MAKE SURE THE PAPERWORK IS FILLED OUT CORRECTLY, ANY ERRORS/OMISSIONS IT WILL HAVE TO BE MAILED BACK TO YOU WITH INSTRUCTIONS ON WHAT TO DO.
6. PAPERWORK IS ACCEPTED MONDAY TO THURSDAY 8:AM TO 3:00PM (any paperwork received outside of this time frame will be processed as time permits).
    - PLACE IT IN THE GREEN TIME SHEET DROP BOX UNDER THE CANOPY IN FRONT OF OUR BUILDING
    - MAIL IT TO ILRC 3033 W 2ND ST N STE 1, WICHITA, KS 67203
    - SCAN AND EMAIL IT TO swickery@ilrcks.org (IF you scan this you will need to mail the originals for items 15 and 16 to our agency)
    - FAX IT TO 316-425-3720 (IF you fax this you will need to mail the originals for items 15 and 16 to our agency.)

If you have any questions about anything contained in this packet, please call 316-942-6300 between the hours of 8am to 4:00 pm Monday through Friday.

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ANSWER THE FOLLOWING QUESTIONS BELOW TO SEE IF A DESIGNATED REPRESENTATIVE IS REQUIRED.

****

1. **CAN** THE CUSTOMER SIGN THIS PAPERWORK FOR THEMSELVES ??????

   A. **"YES"** GO ON TO THE NEXT PAGE MARKED "3" IN THE UPPER RIGHT HAND CORNER

   B. **"NO"** GO ON TO QUESTION "2" BELOW

2. SINCE THE CUSTOMER IS NOT ABLE TO SIGN FOR THEMSELVES YOU WILL NEED TO ANSWER THE FOLLOWING QUESTIONS BELOW TO SEE IF A DESIGNATED REPRESENTATIVE IS REQUIRED.

   A. DOES THE CUSTOMER HAVE A DPOA OR LEGAL GUARDIAN?
      - IF "YES", GO TO STEP "B"
      - IF "NO", GO TO STEP "D"

   B. IS THE DPOA OR LEGAL GUARDIAN ALSO THE WORKER?
      - IF "YES", GO TO STEP "C"
      - IF "NO", GO TO STEP "D"

   C. THE CUSTOMERS DPOA OR GUARDIAN **MUST** SELECT SOMEONE OTHER THAN THE PERSON WORKING TO BE A DESIGNATED REPRESENTATIVE TO SIGN THIS PAPERWORK ON THE CUSTOMERS BEHALF. **SEE ATTACHED CONFLICT OF INTEREST POLICY, IF YOU HAVE FURTHER QUESTIONS PLEASE CALL CASE MANGER.**

      THE DESIGNATED REPRESENTATIVE WILL SIGN THE CUSTOMERS NAME AND PUT "BY" ALONG WITH THEIR NAME ON EACH LINE REQUIRING THE CUSTOMERS SIGNATURE. PLEASE COMPLETE THE FOLLOWING:
      - ITEM "1"
      - ITEM "2"– include copy of court issued Guardianship/DPOA documents with this paperwork.

   D. YOU **DO NOT** HAVE TO COMPLETE DESIGNATED REPRESENTATIVE PAPERWORK.
      - GO ONTO THE NEXT PAGE MARKED "3" IN THE UPPER RIGHT HAND CORNER.

Kansas
Department of Aging
and Disability Services

Home and Community Based Programs

Appointed Designated Representative Form
(Effective:_____to_____)

To be completed by the Appointed Designated Representative:

Name _____

Address _____

Phone _____

Email _____

Relationship to Participant _____

By signing below, as the designated representative, I certify:

1. I am an adult 18 years of age or older.
2. I am not prohibited from serving as a designated representative based on a background check, abuse, neglect, and exploitation check or Office of Inspector General Medicaid exclusion list check.
3. I understand and agree to direct home and community based services for the above named individual while engaging and supporting the individual, as much as possible, in choice and self-direction.
4. I understand that as the designated representative, I do not have authority, unless otherwise authorized, to act on the above named person's behalf in situations other than as the employer for directing home and community based services provided through KanCare.
5. I understand that as the designated representative, I have the duty to perform my duty and responsibility as the employer to hire, fire, manage, train, and monitor the direct service worker(s) and ensure compliance with program, state and federal rules and regulations on behalf of the participant without compensation.
6. I acknowledge that as the designated representative, I am prohibited from being paid with Medicaid dollars to provide supports to the individual represented.
7. This appointment lasts for **no longer than one year** from the date of my signature below. In anticipation of expiration of this form, an updated form must be provided. If the length of the appointment is less than one year, the appointment should be indicated using the effective dates above.

Participant Signature _____ Date: _____

Printed Name _____ ☐ Participant Cannot Sign

Representative Signature _____ Date: _____

Printed Name _____

Kansas
Department of Aging and Disability Services

Home and Community Based Programs

Appointed Designated Representative Form

(Effective:_____to_____)

(2)

To be completed by the Individual receiving HCBS Program Services:

By signing below, I understand the following:

1. I have chosen the below-named person to act as my Designated Representative for the purpose of directing my Home and Community Based Services as identified in my integrated service plan of care;

2. This appointment lasts for **no longer than one year** from the date of my signature below. In anticipation of expiration of this form, an updated form must be provided. If the length of the appointment is less than one year, the appointment should be indicated using the effective dates above.

3. I can cancel this consent at any time before its expiration by informing my Care Coordinator or Financial Management Services Provider that I wish to cancel this consent and by completing and signing the **Revocation of Designated Representative form**.

4. I understand that with supporting documentation this consent may be cancelled if it is determined that my designated representative is not acting in my best interest, does not show the ability to self-direct my services according to the integrated service plan of care or the HCBS program requirements, or if it is discovered that the appointed designated representative has a conflict of interest or has committed fraud, waste, and abuse.

   ☐ I have included supporting documentation in cases where the designated representative has been appointed through the court. This form shall not be considered complete without the court documentation when appointed through the court process.

Participant Signature _____ Date: _____

Printed Name _____ ☐ Participant Cannot Sign

Guardian/DPOA Signature _____ Date: _____

☐ Guardianship Documents Attached ☐ DPOA Documents Attached

If the individual is unable to sign this appointment, a third party witness must sign. The third party witness may not be the Care Coordinator, Community Service Provider, Targeted Case Manager, Personal Care Attendant or the Designated Representative.

Witness Signature _____ Date: _____

Printed Name _____

Relationship _____

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PD / FE / IDD / TA / TBI WAIVERS
Customer Verification of Signature

The State of Kansas requires us to verify that your signature on correction sheets and paperwork matches the signature we have on file. If we ever have a question about your signature we can refer back to this page for verification. If we have any further questions, we will contact you.

_____

Customer Name (The person receiving HCBS services name goes on this line do not list the parent/guardian or DPOA name). Please print.

_____ _____

Customer Signature Date

IF the customer is unable to sign for themselves for any reason see "Signature of Limitations" below ↓ for further instructions:

→ Signature of Limitations

- *In all situations, the expectation is that the beneficiary (customer) provides oversight and accountability for those providing services. Signature options are provided in recognition that a beneficiary's (customer) limitations may make assistance necessary in carrying out this function.*
- *A designated signatory can be anyone who is aware of HCBS services that are being provided.*
- ***The direct support worker CANNOT sign any paperwork on behalf of the beneficiary (customer) or make corrections to their hours on behalf of the beneficiary (customer).***

Example: **Susan Sample** — Customer Name

Jane Doe for Susan Sample — Customer Signature

_____

Customer Representative Name (print name)

_____

Customer Representative Signature

_____

Representative's relationship to customer (POA, DPOA, Guardian, etc.):

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CUSTOMER PERSONAL INFORMATION SHEET

CUSTOMER NAME (print) _____
FIRST MIDDLE LAST

ADDRESS _____

CITY/STATE _____ ZIP CODE _____

HOME PHONE (____) _____ CELL PHONE (____) _____

SOCIAL SECURITY # _____ DATE OF BIRTH ____/____/____

EMAIL ADDRESS (FOR ILRC COMMUNICATION PURPOSES ONLY): _____

_____ _____
CUSTOMER'S SIGNATURE DATE

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5

NEW HIRES AND BACKGROUND CHECK FEES AGREEMENT

NEW HIRES:

ALL NEW DIRECT SUPPORT WORKER PAPERWORK MUST BE ACCURATELY COMPLETED AND RETURNED WITHIN 3 DAYS OF THE DATE OF HIRE. NO TIME WORKED PRIOR TO THIS DEADLINE WILL BE PAID BY ILRC AS FISCAL AGENT. MISTAKES ON THE PAPERWORK WILL ALSO DELAY THE DATE A WORKER WILL BECOME ELIGIBLE FOR ILRC AS FISCAL AGENT PROVIDED FINANCIAL MANAGEMENT SERVICES (FMS).

****

BACKGROUND CHECK FEE'S:

WE ARE REQUIRED TO PERFORM BACKGROUND CHECKS ON EACH NEW DIRECT SUPPORT WORKER.

IN THE DIRECT SUPPORT WORKER PAYROLL REGISTRATION PAPERWORK AN ILRC STAFF MEMBER WILL DESIGNATE WHICH OPTION BELOW APPLIES:

OPTION 1- THIS OPTION APPLIES TO THE FIRST 5 WORKERS YOU HIRE.

A $30.00 REFUNDABLE DEPOSIT ($60.00 IF DSW HAS AN OUT OF STATE DRIVERS LICENSE) MUST BE SUBMITTED WITH THE BACKGROUND CHECK AUTHORIZATION PAPERWORK. **THEY MUST PASS ALL** OF THE REQUIRED BACKGROUND CHECKS IN ORDER TO BE ELIGIBLE FOR THE REFUND. THIS FEE MUST BE PAID UPON RECEIPT OF THE NEW DSW PAPERWORK BEFORE THE BACKGROUND CHECKS WILL BE RUN. **PLEASE DO NOT SEND MONEY ORDERS.**

OPTION 2 – THIS OPTION APPLIES WHEN YOU HAVE EXCEEDED 5 WORKERS.

"YOU" THE CUSTOMER HAVE EXCEEDED MORE THAN 5 WORKERS "YOU" THE CUSTOMER/EMPLOYER MUST PAY THE $30.00 BACKGROUND CHECK FEES ($60.00 IF DSW HAS AN OUT OF STATE DRIVERS LICENSE).

***ONCE THE BACKGROUND CHECK FEE'S HAVE BEEN IMPLIMENTED IN OPTION 2, IF "YOU" THE CUSTOMER/EMPLOYER CONTINUE TO BE EXCESSIVE WITH HIRING AND FIRING OF DIRECT SUPPORT WORKERS YOU MAY BE ASKED TO FIND A NEW PAYROLL PROVIDER. THIS SIGNED AGREEMENT SERVES AS YOUR NOTICE.

****

_____
Customer Name (Print)

_____ _____
Customer Signature Date

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KANSAS AUTHENTICARE CALL IN SYSTEM AGREEMENT

The Kansas Authenticare call in system is a mandatory system put in place by the State of Kansas. Using the system is a condition of HCBS FMS service, failure to use it will result in disqualified hours. The system mandates that your Direct Support Worker use it to record the hours they are working for you. The system is simple to use, your Direct Support Worker will be given instructions along with their ID number. **Direct Support Workers are not to overlap hours with another worker who is already clocked in.**

"You" the Customer MUST have a phone available for your Direct Support Worker to clock in and out with. If you do not have a phone your Direct Support Worker will not be allowed to work until you obtain one, unless your worker has been approved for the mobile app. This system is mandatory and it's your responsibility as the Customer to make sure a phone is available for your Direct Support Worker to use at all times.

- **The HCBS services are to be provided to "You" the CUSTOMER ONLY do not have your Direct Suport Worker performing tasks for anyone else that resides in the household while they are clocked IN.**
- **Direct Support Workers CANNOT be clocked in at the same time.**
- **"You" the Customer, are responsible for adding or removing any registered numbers to your record in Kansas Authenticare. Workers time will not be reversed if they have clocked in and out using a registered phone listed on your record. Workers numbers are not allowed to be registered.**
- **If your Direct Support Worker misses a clock in OR clock out a claim correction form can be submitted to the Payroll Department. HOWEVER if the worker fails to clock in and clock out for their entire shift on any given day no correction forms will be accepted, the Kansas Authenticare call in system is mandatory.**
- **If "You" the customer goes into the hospital, rehab or nursing facility, jail, out of State etc., please let us know immediately. Your worker(s) are NOT allowed to clock in and out during this time this is Medicaid Fraud and will be reported to Medicaid, the Kansas Attorney General's Office, and the insurance company.**

Corrections are limited to 6 per month. Any corrections in excess of this limit will result in corrective action procedures. Any customer who has worker(s) who have exceeded the monthly limit 2 or more times will not be eligible for any corrections of errors or omissions for any of their worker without possible additional fees.

By signing below you the Customer agree to the above agreement.

_____
Customer's Name Print

_____ _____
Customer's Signature Date

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1

FINANCIAL MANAGEMENT SERVICES AGREEMENT

This Financial Management Services Agreement (the "**Agreement**") is made and entered into this ____ day of _____, 20__ by and between Independent Living Resource Center (the "**FMS Provider**") and _____ (the "**Customer**").

WHEREAS, the Customer is a participant in a Home and Community Based Services ("**HCBS**") waiver program under Medicaid (the "**Program**") administered by the Kansas Department of Aging and Disability Services ("**KDADS**") through KanCare and has elected to self-direct his/her services under the Program by employing one or more direct support workers (each a "**Caregiver**");

WHEREAS, the Customer is the sole employer of his/her Caregiver (s);

WHEREAS, the purpose of a Caregiver is to provide assistance and support to the Customer in accordance with the Customer's integrated service plan (the "**ISP**") under the Program;

WHEREAS, as a self-directed participant in the Program, the Customer is required to contract with an entity that has contracted with KDADS to provide financial management services ("**FMS**") under the Program;

WHEREAS, the FMS Provider has contracted with KDADS to provide FMS under the Program; and

WHEREAS, the Customer desires to retain the FMS Provider to provide FMS, including, but not limited to (i) processing of time worked by the Customer's Caregiver(s), (ii) billing KanCare on the Customer's behalf, (iii) distributing pay checks or electronic deposits for services rendered by each of the Customer's Caregivers under the ISP, (iv) withholding, filing and paying appropriate taxes for Caregiver services under the ISP, and (v) information and assistance services to assist the Customer in understanding his/her role and requirements as the employer of each Caregiver and his/her responsibilities under participant-direction.

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

Section 1. **Duties of the Customer**. The Customer's duties under this Agreement include, but are not limited to, the following:

(a) Strictly comply with:
  (1) The Customer's ISP, Customer Service Worksheet (if any), and any all other Program requirements;
  (2) Any and all instructions, rules or policies maintained by the FMS Provider with regard to billing and payment; and
  (3) Any and all Kansas statues, regulations, or policies (including, but not limited to, KDADS's Field Service Manual, as amended from time to time) relating or pertaining to services provided under the Program and for payment for such services; and

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(b) Choose and direct his/her support services under the Program (e.g., Personal Care Services and Enhanced Care Services);
(c) Understand the roles and responsibilities of the FMS Provider;
(d) Notify the FMS Provider of the Customer's "Designated Representative" (if any), using forms provided by the FMS Provider;
(e) Perform all of the roles and responsibilities as employer of the Caregivers, including, but or limited to, the following:
  (1) Recruit, select, interview, hire, train, supervise, and dismiss Caregivers;
  (2) ***Notify the FMS Provider when the Customer desires to hire an individual as a Caregiver, so that the FMS Provider can begin processing the potential hire;***
  (3) Ensure that all employment paperwork, including Form W-4, Form K-4, and Form I-9, is completed and processed in a timely manner by referring each Caregiver to the FMS Provider as soon as the Customer decides that he/she wants to hire such Caregiver and ***before such Caregiver begins to work for the Customer;***
  (4) Negotiate and sign an Employment Agreement with each Caregiver that clearly identifies the responsibilities of the Customer and Caregiver;
  (5) Comply with the following obligations regarding Form I-9:
    i. Require each Caregiver hired by Customer to complete Section 1 of Form I-9 on or before the first day of employment;
    ii. Complete and sign Section 2 of Form I-9 after reviewing original documents from the Caregiver;
    iii. Send a copy of the completed Form I-9 (along with copies of documents provided for Section 2 of the Form I-9) to the FMS Provider for filing and review; and
    iv. Maintain the original Form I-9 and copies of documentation in the Customer's files.
  (6) In accordance with the ISP, determine the tasks to be performed by Caregiver(s) and where and when they are to be performed;
  (7) Manage and supervise the day-to-day HCBS activities of each Caregiver;
  (8) Ensure each Caregiver has resources and training on the use of the AuthentiCare ® KS IVR system;
  (9) Ensure that the time worked by each Caregiver is delivered according to the ISP;
  (10) Approve and validate the time worked by the Caregiver;
  (11) Maintain control and oversight of each Caregiver to prevent fraud, waste, abuse and ensure compliance with federal and state rules and regulations;
  (12) Ensure each Caregiver is aware of their employment requirements and job responsibilities upon signing the Employment Agreement;
  (13) Develop an emergency worker back-up plan in case a substitute Caregiver is ever needed on short notice or as a back-up (short-term replacement Caregiver);

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(14) Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by the KanCare Provider Agreement;

(15) Understand and comply with the Program's policies and procedure and federal and state employment laws, including but not limited to the Customer's responsibility to ensure that each Caregiver is paid (a) at least minimum wage for all hours worked, whether or not the hours are approved under the ISP, and (b) overtime wages for all hours over forty that are worked by a Caregiver in the workweek, whether or not the overtime is approved under the ISP;

(16) Provide a safe work environment for the Caregivers;

(17) Provide proper supplies and materials, at the Customer's expense, for each Caregiver to perform his/her duties for the Customer;

(18) As soon as possible **but no later than 24 hours** after learning of a Caregiver's work related injury, report such injusry to the FMS Provider; and

(19) As soon as possible but **no later then 24 hours** after learning of the change in status of a Caregiver (including termination of employment, change in contact information, or Form W-4 and Form K-4 elections), notify the FMS Provider of such change in status and provide information to the FMS Provider regarding the change in status, as required in the FMS Provider's sole discretion;

(f) As soon as possible **but not later than 24 hours** after a change in status of the Customer that would make it impossible for the customer to receive services under the Program temporarily or permanently (including, but not limited to, loss of the Customer's eligibility for Medicaid, incarceration in a penal institution or admission to an inpatient or residential hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental disease), notify the FMS provider of such change.

(g) Within **three working days** after a change in contact information for the Customer or his/her Designated Representative (if any) occurs, inform the FMS Provider of such change.

Section 2. **Duties of the FMS Provider.** The duties of the FMS Provider, as agent of the Customer, under this Agreement are as follows:

(a) Comply with the provisions of K.S.A. 39-7, 100 and K.S.A. 65-6201;

(b) Comply with all state and federal Medicaid, KanCare, and KDADS requirements;

(c) Support the Customer's right to self-direct his/her in-home support;

(d) Ensure that the Customer, and not the FMS Provider, has the right to choose, direct and control the services and the Caregivers who provide them without excessive restrictions or barriers;

(e) Provide FMS to the Customer, including but not limited to:

(1) Processing of time worked by Caregiver;

(2) Billing KanCare on the customer's behalf;

(3) Distributing pay checks or electronic deposits for services rendered;

(4) Withholding, filing and paying appropriate taxes;

(5) Assisting the Customer in understanding his/her role and requirements as the employer of each Caregiver and his/her responsibilities under participant-direction;
(6) Assisting the Customer in obtaining a federal employer identification number (FEIN); and
(7) Arranging for unemployment insurance for the Customer;

(f) Provide human resource documentation and payroll services that support the Customer's role as sole employer of each Caregiver, including reviewing and recommending corrections to Forms I-9 submitted by the Customer to the FMS Provider;
(g) As agent of the Customer, conduct background checks on potential Caregivers in accordance with KDADS and other state and federal regulations, review results of background checks, and notify the Customer as to whether a potential Caregiver is eligible for hire based on the results of such background checks;
(h) As agent of the Customer, provide information to Caregivers that outlines the completion of the time-keeping process, wages, and pay days;
(i) Ensure that the customer, not the FMS Provider, determines the terms and conditions of work (when and how services are provided, such as establishing work schedules, work conditions, and tasks to be performed);
(j) Provide information and assistance services to the Customer, as requested by the Customer;
(k) On behalf of the Customer (who is the sole employer), pay wages to each Caregiver in accordance with state and federal laws; provided, however, under no circumstances will the FMS Provider be obligated to pay a Caregiver for any hours exceeding those allowed on the ISP or by the Program;
(l) On behalf of the customer (who is the sole employer), maintain all Caregiver records and documentation, as arequired by KDADS;
(m) On behalf of the Customer (who is the sole employer), arrange for workers' compensation insurance for each Caregiver; and
(n) Upon receiving a report of a Caregiver's workers' compensation injury from the Customer, report such injury to the workers' compensation carrier.

Section 3. **Selection of Caregiver**. The parties agree that the Customer shall have sole discretion whether to hire or continue to employ a particular individual as a Caregiver and that the FMS Provider shall not be involved in such decisions. The Customer understands and agrees that before a Caregiver can begin working:

(a) The Customer must notify the FMS Provider of the Customer's intent to hire the Caregiver so that the applicable processing of the Caregiver (including applicable background checks)can be done by the FMS Provider.
(b) The FMS Provider must notified the Customer that the results of such background checks qualify the Caregiver to be employed under the Program; and
(c) The Customer and the Caregiver must enter into an Employment Agreement.

The Customer understands and agrees that the Customer, not the FMS Provider, shall be liable for any wages owed to a Caregiver who has not been processed by the FMS Provider and/or who performs work outside the scope of the ISP or Program.

Section 4. **Payment to the FMS Provider.** The parties agree that the FMS Provider shall be paid through the Program for the services that the FMS Provider provides to the Customer under his Agreement. ***The Customer understands that KDADS and/or KanCare will not process payments through the Program without proper documentation from the FMS Provider and/or the Customer and that such documentation must be complete and accurate in order to avoid Medicaid fraud.*** Therefore, the customer agrees to cooperate fully with the FMS Provider to ensure that the FMS Provider is paid through the Program for such services and that the documentation regarding Caregiver services that are provided by the Customer to the FMS Provideris complete and accurate. Furthermore, the customer understands and agrees that (a) to the extent that the Program requires the Customer to pay a portion of the Caregiver's services (e.g., a client obligation), the customer must pay the FMS Provider that amount and (b) if KanCare and/or Medicaid refuses to pay for the services of the Caregiver through the Program, the ***Customer is personally liable to the FMS Provider*** for any costs and expenses incurred by the FMS Provider in paying the Caregiver for such services. If the Customer has a monthly client obligation that is assigned to the FMS Provider, the Customer agrees to pay said obligation by the 1st of each month it is assigned.

Section 5. **Payment for Work Not Covered by ISP or Program.** The FMS Provider has no obligation to compensate a Caregiver for any work for the Customer that is not covered by the Customer's ISP or the Program **("Non-Covered Duties").** In the event that a Caregiver performs Non-Covered Duties, the Customer agrees that the Customer is personally liable for compensation owed to the Caregiver for Non-Covered duties (including any overtime wages attributable to Non-Covered duties and/or that are not payable under the Program), and the customer agrees to indemniFy, hold harmless, and reimburse the FMS Provider for any payments it makes to the Caregiver for Non-Covered Duties.

Section 6. **FMS Provider is Not the Common Law Employer for Purposes of Patient Protection and Affordable Care Act Act.** The parties hereby understand and agree that ***the FMS Provider is not the "common law employer" of any Caregiver for purposes of Patient Protection and Affordable Care Act ("PPACA") or under any other law that FMS Provider has no legal obligation to offer health care coverage to any Caregiver.*** The parties further agree and understand that, under the legal standards established by the Internal Revenue Service, the "common law employer" for purposes of PPACA compliance is the Customer. The customer agrees never to argue or raise as a defense in any legal proceeding that the FMS Provider is the "common law employer" of a Caregiver for purposes of PPACA or for any other purpose.

Section 7. **FMS Provider is Not the "Employer" for Purposes of the Fair Labor Standards Act. The parties hereby understand and agree that the FMS Provider is not the "employer" of any Caregiver for purposes of the Fair Standards Act or under any other law that uses the "economic reality test" to determine employer/employee status.** The Customer agrees never to argue or raise as

a defense in any legal proceeding that the FMS Provider is the "employer" of a Caregiver for purposes of the Fair Labor Standards Act or for any other purpose.

Section 8. **Medicaid Fraud.** The Customer agrees and understands that if either the Customer or the Caregiver submits false or inaccurate information regarding the work times or duties performed by the Caregiver, it will be considered Medicaid fraud and exploitation of benefits that the FMS Provider is required to report to the State of Kansas.

Section 9. **Consent to Release Confidential Information.** The Customer consents and authorizes the FMS Provider to release and exchange information related to the services provided by the FMS Provider and any of the Customer's Caregivers (including health information and information that is otherwise confidential) to the following agencies and individuals: The Customer's case manager; the Customer's case management agency or Case Management Entity ("**CME**") (as applicable); a Managed Care Organization ("**MCO**") involved with the Customer's Program; the Customer's Community Developmental Disability Organization ("**CDDO**"); KDADS; the Division of Health Care Finance of the Kansas Department of Health and Environment; HP Enterprises/KS Medicaid Fiscal Agent; KDADS's Quality Assurance Department; AuthentiCare KS; third party insurance carriers; and any other government agency as required by law and Kansas FMS requirements.

Section 10. **Coverage by Caregivers.** The Customer understands and agrees that it is the Customer's sole responsibility (not the FMS Provider's responsibility) to ensure that a Caregiver or someone else is present and available to provide services to the Customer and that the FMS Provider is not liable in any way if a Caregiver or another person is not present or available to provide such services.

Section 11. **Liability.** The Customer understands and agrees the FMS Provider shall not be liable to the Customer for any injuries, claims, loses, expenses, or damages, arising from or in any way relating to the Agreement from any cause or causes including, but not limited to, the negligence, gross negligence, errors, omissions, breach of contract, or breach of warranty by the FMS Provider, any agent, officer, or employee of the FMS Provider, or any Caregiver, or for the intentional misconduct of any Caregiver. The Customer agrees to hold the FMS Provider harmless from any liability of the FMS Provider to a Caregiver, Medicaid, KanCare, or KDADS that is due to the Customer's negligence, gross negligence, errors, omissions, breach of contract, and/or intentional misconduct.

Section 12. **Termination of the Agreement.** This Agreement shall remain in effect pending the earliest occurrence of one of the following events:

(a) Denial of the Customer's Medicaid and/or KanCare eligibility;
(b) Termination/closure of the Customer's applicable HCBS case;
(c) Termination of the Customer's right to self-direct his/her case;
(d) Termination of the Agreement by the FMS Provider, in accordance with Program requirements, including termination for Medicaid fraud or for failure to pay a state ordered client obligation;
(e) Termination of the Agreement by the Customer, following written notification from the customer to the FMS Provider and in accordance with Program requirements.

(f) The effective date of an agreement between the Customer and another entity that provides FMS to the Customer under the Program.

Section 13. **Third Party Beneficiary**. Though KDADS and the CME (if any) from whom the Customer receives case management services under the Program are not parties to this Agreement, the parties specifically intend that KDADS and the CME (if any) each be a third-party beneficiary and, as a result thereof, further acknowledge and agree that KDADS and/or the CME (if any) may, at their option, enforce the terms of this Agreement.

Section 14. **Assignment.** The parties shall not assign, subcontract, or delegate any duties or obligations required by this Agreement to any other individual, agency, or organization. Subject to that limitation, this Agreement shall be binding upon and inure to the benefit of the parties and their heirs, personal representatives, successors, and assigns.

Section 15. **Amendment**. This Agreement may only be modified by a written agreement signed by the parties hereto. No failure by either party to insist upon the strict performance of this Agreement on one or more occasions shall constitute a waiver of any right or remedy hereunder.

Section 16. **Severability.** The invalidity or unenforceability of any provision of this Agreement shall not affect the other provisions hereof and this Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

Section 17. **Entire Agreement**. This Agreement has been entered into in good faith by the parties. This Agreement sets forth the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes any and all prior and contemporaneous negotiations, understandings, and agreements with regard to the subject matter hereof, whether oral or written. In entering into this Agreement, neither the FMS Provider nor the Customer has made or relied upon any representation or provision not set forth herein.

Section 18. **State Law**. The terms and provisions of this Agreement shall be construed in accordance with and governed by the laws of the State of Kansas. The titles of the Sections, Subsections, Paragraphs, and Subparagraphs in this Agreement have been inserted for convenient reference only and shall not affect the construction of this Agreement.

Section 19. **Venue.** For any action to enforce this Agreement by KDADS or CME (if any), venue shall solely be in the District Court of Shawnee County, Kansas. For all other actions to enforce this Agreement, venue shall solely be in District Court of Sedgwick County, Kansas.

Section 20. **Compliance with Program**. It is the intent of the parties that this Agreement be interpreted to comply with the Program requirements.

Section 21. **Signatures.** This Agreement (and any amendments, modifications, or waivers in respect hereof) may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which shall constitute one and the same document. Facsimile signatures or

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signatures emailed in portable document format (PDF) shall be acceptable and deemed binding on the parties hereto as if they were originals.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

INDEPENDENT LIVING RESOURCE CENTER

By: _____
Signature

_____
Print name

_____
Title

CUSTOMER (or Customer's parent, legal guardian, or legal representative)

_____
Signature

_____
Print Name of Customer

_____
If Customer does not sign, the relationship of the person signing to the Customer

Customer Medicaid ID #: _____

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SS-4 INSTRUCTIONS

With the SS4 form you are allowing Independent Living Resource Center d.b.a. ILRC as Fiscal Agent to apply for an Employer Identification Number (EIN) on your behalf with the IRS. We MUST have this information on file for your records. Please fill this out with customer's information regardless of their age.

DO NOT LIST GUARDIAN'S, PARENTS ETC. ON THIS FORM SEE ITEM 8 BELOW.

1. Print the customer's name on line 1
2. Print the customer's address on line 5a
3. Print the customer's city state and zip on line 5b
4. Print the customer's name on line 7a
5. Print the customer's SSN on line 7b
6. Line 18 answer "Yes" or "No"
    - **IF "Yes" write the EIN number you were issued by your previous FMS provider on this line.**
7. In the box with the "X" by it, print the Customers Name and phone number in the box to the right of it.
8. In the box with the "*" by it, the customer will sign and date it here.
    - **IF the customer is unable to sign for themselves giving assistance to the customer is acceptable <u>but the customer's signature is required on this form.</u> NO ONE ELSE SHOULD LIST THEIR INFORMATION ON THIS FORM (guardians, parents etc.).**
    - **You can assist the customer with a "hand" over "hand" technique that is permissible if needed.**

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Form **SS-4** (Rev. January 2010)

Department of the Treasury Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ See separate instructions for each line. ▶ Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name
Independent Living Resource Center d.b.a. ILRC Fiscal Agent

4a Mailing address (room, apt., suite no. and street, or P.O. box)
3033 W 2ND ST N

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
WICHITA, KANSAS 67203

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located
SEDGWICK, KANSAS

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ▶

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☑ Other (specify) ▶ HCSR
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

9b If a corporation, name the state or foreign country (if applicable) where incorporated — State: Kansas — Foreign country:

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ▶
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ▶ HCSR
- ☐ Banking purpose (specify purpose) ▶
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Created a pension plan (specify type) ▶

11 Date business started or acquired (month, day, year). See instructions.
01/01/2016

12 Closing month of accounting year DECEMBER

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶

16 Check one box that best describes the principal activity of your business.
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-agent/broker
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) ▶ HCSR ☐ Wholesale-other ☐ Retail ☐ Health care & social assistance

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No
If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name	Designee's telephone number (include area code)
MICHAEL STREIT	(316)942-6300
Address and ZIP code	Designee's fax number (include area code)
3033 W 2ND ST N, WICHITA, KANSAS 67203	(316) 670-1429

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.

Applicant's telephone number (include area code)

"X" Name and title (type or print clearly) ▶ HCSR

Applicant's fax number (include area code)

"X" Signature ▶ Date ▶

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FORM 2678 EMPLOYER/PAYER APPOINTMENT OF AGENT

This form is required to be filled out. With it, you are appointing Independent Living Resource Center d.b.a. ILRC as Fiscal Agent to remit Federal unemployment, FICA and Medicare taxes on your behalf as well as to file the applicable quarterly tax returns on your behalf. Please fill this out with customer's information regardless of their age.

DO NOT LIST GUARDIAN'S, PARENTS ETC. ON THIS FORM SEE ITEM 3 BELOW.

1. Print Customers name on line 2

2. Print the Customers address information on line 4

3. At the bottom of this form by the "X" the Customer will fill in the boxes with signature, date, print name and daytime phone number.

   - **IF the customer is unable to sign for themselves giving assistance to the customer is acceptable <u>but the customer's signature is required on this form.</u> NO ONE SHOULD LIST THEIR INFORMATION ON THIS FORM (guardian, parent etc).**

   - **You can assist the customer with a "hand" over "hand" technique that is permissible if needed.**

Form **2678** **Employer/Payer Appointment of Agent**

(Rev August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.
- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use

Part 1 **Why you are filing this form...**

(Check one)

☑ You want to appoint an agent for tax reporting, depositing, and paying.

☐ You want to revoke an existing appointment.

Part 2 **Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.**

1 **Employer identification number (EIN)** ☐☐ – ☐☐☐☐☐☐☐

2 **Employer's or payer's name** (not your trade name)

3 **Trade name** (if any)

4 **Address**

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 **Forms for which you want to appoint an agent or revoke the agent's appointment to file.** (*Check all that apply.*)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☑	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☑	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X **Sign your name here**

Print your name here

Print your title here HOME CARE SERVICE RECIPIENT

Date / /

Best daytime phone

Now give this form to the agent to complete.

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Part 3: Agent information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6 Agent's employer identification number (EIN): 32-0504847

7 Agent's name (or trade name): ILRC as Fiscal Agent

8 Trade name (if any):

9 Address: 3033 W 2nd St N
Number Street Suite or room number

Wichita | KS | 67203
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments and to the best of my knowledge and belief, it is true, correct, and complete.

X Sign your name here: Michael Streit

Print your name here: Michael Streit

Print your title here: Controller

Date: / /

Best daytime phone: 316-942-8300 X229

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All HCBS Medicaid providers will be required to first bill private insurance before submitting a claim to Medicaid for your in-home services. If you, or your child, are covered by a private health insurance plan, you can help us to expedite this process by sending us your information.

PLEASE PRINT BELOW

CUSTOMER NAME:	
SOCIAL SECURITY NUMBER:	
DATE OF BIRTH:	
STREET ADDRESS:	
CITY:	
STATE:	
ZIP CODE:	

IF YOU HAVE NO INSURANCE PLEASE WRITE "NO INSURANCE" BELOW

PRIMARY INSURANCE INFORMATION

INSURED NAME:	
HEALTH INSURANCE COMPANY:	MEDICAID
POLICY ID / MEDICAID NUMBER:	
GROUP NUMBER:	
INSURED DATE OF BIRTH:	

IF you also covered by any other health insurance such as Medicare or private insurance? If no, write "no insurance" below. If you are….fill in this information below:

Please send in a copy of the front and back of your insurance card(s) with this form.

SECONDARY INSURANCE INFORMATION

INSURED NAME:	
HEALTH INSURANCE COMPANY:	
POLICY ID:	
GROUP NUMBER:	
INSURED DATE OF BIRTH:	
RELATIONSHIP TO INSURED:	
INSURED PLACE OF EMPLOYMENT:	
ADDRESS IF DIFFERENT FROM CUSTOMER:	
GENDER MALE / FEMALE:	

_____ **I HAVE NO SECONDARY INSURANCE**

_____ _____

SIGNATURE **DATE**

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Welcome to the Independent Living Resource Center

This handbook was made especially for those individuals who have shown an interest in ILRC services. The handbook's content has been designed to acquaint you with the ILRC and the services it can provide. If you have any questions or comments, feel free to contact any of the staff at our office at any time.

Our Philosophy: People with disabilities are entitled to the same civil rights, options and control over their lives as people without disabilities.

Who can receive services?
Any individual, who has a physical, mental or emotional impairment expressing an interest in participating in the program is eligible. This program complies with the provisions of the Rehabilitation Act of 1973 (Pub. Law 93-112), Section 504, Title VII and Title IX of the Civil Rights Act, and Titles I and III of the Americans with Disabilities Act. This means that no person shall be excluded from participation, denied any benefits or subjected to any form of discrimination because of his/her race religion, color, sex, national origin, ancestry, age, disability or political affiliation, nor does the ILRC discriminate based on sexual orientation/preference.

Participation in ILRC programs is based on your needs as determined by the initial intake process, and the program's ability to meet those needs. Requests for alternate forms of communication can be made through IL staff for any event or service conducted through ILRC. Requests are preferred <u>three business days</u> prior to the day of need for the service. Should you have an immediate need for accommodation please contact a staff member of ILRC to see if arrangements can be made.

Requirements: Consumers are generally 18 years of age or older. Information and referral services and technical assistance may also be offered to friends, family members and acquaintances of people with disabilities. Consumers must exhibit a commitment toward achieving maximum levels of independence.

Limitations: ILRC encourages consumers to access services that already exist in the community. When necessary, ILRC advocates for inclusion of consumers in all levels of society. The ILRC is limited in its ability to serve individuals with a current history of violent behavior that imposes an immediate danger to themselves or others. Such persons will be referred to more appropriate community based services.

The Core Services

Advocacy: Advocacy and legal assistance and/or representation in obtaining access to those benefits, services and programs to which an individual with a disability may be entitled.
Information & Referral: On issues, topics and services available for individuals with disabilities, including housing, transportation, attendant services, accessibility, civil rights.
Independent Living Skills Training: Instruction to develop independent living skills in areas such as personal care, financial management, social skills, employment skills and household management.
Peer Support: Counseling, teaching, information giving, and similar kinds of contact provided by other individuals with disabilities.
Transition/De-institutionalization: Assistance is offered to people transitioning out of institutions or who are at risk of being placed in one. Youth Services for are also offered under this service.

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Your Rights at ILRC

- You have the right to be treated as an individual, with feelings, emotions and preferences.
- You have the right to privacy, including privacy of your records and program.
- You have the right to be the primary decision maker in any program planning, decision making, and implementation concerning you.
- You have the right to confidentiality and access to your record under law and per agency policy.
- You have the right to express disagreement with and correction of the material in your file.
- You have the right to accept or refuse services.
- You have the right to appeal any decision made that concerns you.
- You have the right to participate in all aspects of local community life.
- You have the right to education and training which will allow you to develop the skills necessary to reach your personal goals.
- You have the right to vote.
- You have the right to follow your own religious beliefs.
- You have the right to live free of discrimination in employment and in your access to public services and government programs.

There are other rights, but this list summarizes the ones we work most closely with in your life.

Your Responsibilities at ILRC:

- You are expected to share the responsibility of developing and working on the ILP.
- During appointments, distractions should be kept at a minimum.
- Notification of cancellations of appointments should be done as early as possible.
- Other people have rights. Act in a manner which does not limit or infringe upon those rights.

Referral Process

A consumer may contact the ILRC directly, or a professional (i.e., and agency such as health service providers, social service agencies, or mental health associations) or friend may refer individuals. Services are provided if the consumer desires them. Depending on the particular program or situation, a referral may mean that we will contact you about your desire for services.

Independent Living Plan

If services are recommended and the consumer agrees, an Independent Living Plan (ILP) is developed. To develop the ILP, a cooperative effort is required between you and the Independent Living Specialist working with you. If you wish to involve family members or an advocate, that is your choice. The following is a breakdown of an ILP:

Goals: Written indication of the direction you plan for yourself and services ILRC can provide.
Objectives: Detailed steps you must take to achieve your goals that can be measured.
Time Frame: How long you and the other team members expect it will take to meet the objectives.

Your conduct at ILRC

Services may be terminated if any of the following occurs:

- Engage in any activities that constitute abuse, whether physical, verbal, financial or emotional to any member/members and/or staff of ILRC. Display any inappropriate behavior, including disorderly or obscene conduct, fighting, or threatening violence on the premises whether verbally or physically.
- Possess dangerous or unauthorized materials or weapons such as firearms, knives, or explosives while on ILRC property.
- Engage in criminal conduct while on ILRC property.
- Damage, destroy or steal ILRC property.
- Disregard direction from ILRC staff, volunteers, or associates.

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Discontinuing Programs

Consumers may leave ILRC services for any of the following reasons:

- The Independent Living Plan (ILP) is completed, or the consumer wishes to discontinue services.
- The consumer and the staff person working with them feel the program is no longer helping the consumer, or ILRC feels the consumer is no longer involved in the ILP process.
- Staff may determine at any point to stop services. You will be notified that IL services will cease.

File Access

All consumer files are confidential. Direct access to them is limited to designated staff, and all others must have written authorization from you. Only the Executive Director can authorize access to an individual's files by outside sources. You also have access to your file, and may view it upon request to make notes about information in the records, request copies of any information, generated at the ILRC, or request an explanation of the records and evaluations in the file.

Consumer Appeal Process

Consumers have the right to appeal any staff decisions affecting the status of their services.

Procedure

1. The consumer must notify their Independent Living Resource Center is writing of their disagreement with staff decision affecting services. Examples of such decisions would be the discontinuation of services, the stated inability of decision by the staff not to fulfill a request for services the staff deem inappropriate, etc.
2. If, after review of the situation and consultation with the ILRC staff member supervisor, the ILRC is still convinced that the decision is the right one, the ILRC will specify to the consumer, in writing, the reason for the decision. This will be mailed within ten (10) working days. The decision will include a description for the process for continuing the appeal.
3. If the consumer wishes to continue the appeal, he/she shall request that the ILRC supervisor and/or the Director meet with him/her and hear the appeal in person. The consumer may represent himself/herself or have an advocate, attorney or a parent/guardian act on his/her behalf. The consumer may present relevant evidence and testimony. Following the meeting one of the following decisions will be made by the Director: the consumer's appeal is justified, the consumer's appeal is not justified, or the consumer and organization will reach a compromise. This decision will be communicated in writing to all parties, and the decision of the Director is final.

CLIENT ASSISTANCE PROGRAM

You may call the Client Assistance Program operated for all individuals who receive services form programs like the ILRC and Vocational Rehabilitation. The number is 1-800-432-2326.

SATISFACTION SURVEYS

ILRC conducts an annual satisfaction survey that is mailed to the address on file with a prepaid return envelope to all ILRC participants active during the prior calendar year. You may complete anonymously or include a contact information on the survey. You may call and give direct feedback to the ILRC Program Manager or the Executive Director at 316-942-6300.

EQUAL EMPLOYMENT OPPORTUNITY STATEMENT

The Independent Living Resource Center follows the philosophy that no person shall be excluded from participation in, denied any benefits of, or be subject to any form of discrimination due to race religion, color, sex, national origin, ancestry, age, disability, or sexual orientation/preference.

Consumer Signature _____ Date _____

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IL Waiver for Independent Living Plan

I waive the right to developing an Independent Living Plan, including any Life Skills Training at this time. I understand that I can contact my Consumer Advocate at Independent Living Resource Center and begin the process to develop an Independent Living Plan at anytime.

Consumer Name: _____
First Name Middle Initial Last Name

Consumer DOB: _____

Consumer Signature: _____

Date: _____

For Staff Use Only

Staff Signature: _____

Staff Name (Please Print): _____

Date: _____

Independent Living
RESOURCE CENTER

Who Do We Help?

ILRC helps people with all types of disabilities, whether the disability is temporary or permanent. We are also a resource for families, friends, caregivers and others who need information or assistance. We are located in south-central Kansas, but anyone can contact us at no cost.

How Do We Help

ILRC provides assistance in locating resources, whether internal or external, to people with disabilities. We work with individuals, their families and caregivers to help them choose the options that are best for them. We believe that people with disabilities are in the best position to know what kind of services and help they need to live independently.

Core Services

- Information and Referral
- Peer Support
- Advocacy
- Independent Living Skills Training
- Transition/De-Institutionalization

Information & Referral (I&R)

ILRC staff use I&R as the gateway to providing information, knowledge, and resources in an efficient manner to people with disabilities. Staff listen to and assist people with locating resources and developing tactics for individuals to resolve barriers to access in their communities.

Peer Support

We offer the opportunity for people with disabilities to meet and gain support from others in similar circumstances as well as socializing with their peers. Peer support is offered in groups or individually and is based around the person's needs.

Advocacy

ILRC staff work with people individually or in groups to ensure full participation in their communities. We also empower people to make change systematically through legislation and public policy. Our Disability Advocates 4 Action (DA4A) team is a group of people with and without disabilities who meet to work on these advocacy goals.

Independent Living Skills Training

ILRC offers a wide variety of classes and one-on-one trainings; cooking & nutrition in a fully accessible kitchen, typing and computer training, blind and low vision training as well as daily living skills such as money and home management, transportation, hygiene, social skills and communication skills.

Transition / De-Institutionalization

We assist with the transition of people with disabilities from nursing homes and other institutions to home and community based living. In addition, we provide assistance to those at risk of entering an institution and help youth with disabilities integrate into their community.

PROGRAMS

Greater Expectations

As part of the Independent Living Resource Center, Greater Expectations mission is to be a catalyst for growth and opportunities for individuals ages 18-35 with high functioning autism. Using evidence based interventions and strategies, our goal is to understand how autism impacts each individual, develop personalized "visions" and "goals" and pair that with our structured program targeting the key areas of deficit.

Within an environment of structure and support, our highly qualified staff facilitate skill acquisition, social connections, personal freedom and independence, meaningful employment and much more for a fulfilling and meaningful quality of life.

For more information contact us at ILRC at 316-942-6300.

Our Philosophy

People with disabilities are entitled to the same civil rights, options and control over their lives as people without disabilities.

Independent Living Resource Center
3033 W. 2nd St. North Wichita, KS 67203
Office Hours **M-F 8:00 am - 4:30 pm**
Phone **316-942-6300**
Fax **316-942-2078**
Toll Free **800-479-6861**

Memorial / Honor Program

Remember or honor a loved one by giving a gift in their name. For gifts of $15 or more, the name will become a part of our donor wall, prominently displayed in our building. If you have questions, please contact ILRC.

Funding

Established in 1984, ILRC is a 501(c)3 non-profit organization. Services are made possible through partial funding from the State of Kansas Department for Children and Families, Division of Rehabilitation Services, as well as local grants and private donations. ILRC receives no United Way funding.

OTHER SERVICES

Medical Equipment Loans

Our Medical Equipment Recycling Network (MERN) offers new and used medical equipment at no cost. Donations of equipment such as walkers, wheelchairs and adaptive bath equipment or anything else are appreciated and may be tax-deductible. MERN hours are 8:00am to 4:00pm – Monday through Friday.

Personal Assistant Services (PAS)

ILRC provides Fiscal Management Services (FMS) for eligible persons with disabilities desiring to self-direct their own personal care services under the Kansas Medicaid HCBS Waiver Program. Fiscal Management Services include: Processing payroll weekly for your Direct Support Worker, work related payroll tax returns including unemployment insurance and worker's compensation. Information and Assistance is also provided to beneficiaries' families and representatives self-directing their services. For more information contact us at 316-942-6300.

To Support ILRC

To donate by mail, make checks payable to Independent Living Resource Center and send to our address.

Or you may donate online using a credit card: **www.ilrcks.org**

EVV Frequently Asked Questions

A Quick Guide to Understanding EVV

What is EVV?

"EVV" stands for Electronic Visit Verification. EVV is a way to record the date, time, and place your workers provide services to you.

What do they mean by "electronic?" What do they mean by "verification?"

When talking about EVV, "electronic" means using an electronic device to record the date, time and place your worker provides services to you. The most common devices are cell phones, tablets, and computers.

When talking about EVV, "verification" means using technology to prove that both you and your worker are at the same place at the same time. This verification only needs to happen when your worker starts each shift and ends each shift.

I don't want the government to know where I am? What about my privacy?

EVV systems should be designed to protect your privacy. The information about where you are should not be shared with anyone except the people who process paychecks.

Do I have to use EVV?

If you receive paid help around your home and community, you will probably need to use EVV. States are required to implement EVV or face a penalty from the federal government. Most states will have EVV ready to go by January 1, 2020.

When did this start? I've never heard of EVV before.

Some states have used EVV for a while in personal care and home care services. Congress passed a law in 2016 requiring all states to use EVV or pay a penalty. States have been working on plans to be ready by the January 2020 deadline.

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ATTENTION PAYROLL REGISTRATION PACKETS

11/18/2016

EFFECTIVE IMMEDIATELY, IN COORDINATION AND COMPLIANCE WITH ALL STATE REGULATIONS REGARDING HOME AND COMMNITY BASED SERVICES AND FINACIAL MANAGEMENT (FMS) SERVICES, ILRC FISCAL AGENT HAS IMPLEMENTED THE FOLLOWING POLICY.

ALL REQUIRED PAPERWORK MUST BE COMPLETED AND ALL REQUIRED BACKGROUND CHECKS MUST BE PASSED BEFORE ANY DIRECT SUPPORT WORKER THAT YOU HIRE CAN START WORKING FOR YOU UNDER THIS PROGRAM.

THE BACKGROUND CHECK PROCESS CAN TAKE UP TO 4 WEEKS BEFORE ALL OF THE RESULTS ARE RECEIVED FROM THE STATE.

WE ASK THAT YOU DO NOT CALL ILRC FOR STATUS UPDATES ON WHERE YOU ARE AT IN THE PROCESS.

ONCE YOUR DIRECT SUPPORT WORKER HAS PASSED ALL OF THE REQUIRED BACKGROUND CHECKS:

A PIN # WILL BE ISSUED BY SABRINA FROM ILRC AND EMAILED TO YOUR WORKER ALONG WITH A FOLLOW UP PHONE CALL TO THEM TO LET THEM KNOW THEY ARE ELIGIBLE TO WORK FOR YOU UNDER THE HCBS PROGRAM.

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NOTICE OF PRIVACY PRACTICES FOR INDEPENDENT LIVING RESOURCE CENTER

Dear Customer and or Direct Support Worker

Attached to this letter you will find a Notice of Privacy Practices describing the health information practices of Independent Living Resource Center (ILRC) and its affiliates. We are required by federal law to provide this notice to persons who use our services.

The following is a brief summary of the contents of the Notice. We encourage you to read the entire Notice and ask any questions you may have concerning its contents.

Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights.

- Right to inspect and copy
- Right to request amendment
- Right to an accounting of disclosures
- Right to request restrictions on certain uses and disclosures
- Right to request alternative means of communication
- Right to receive a paper copy of the Notice

How To File Complaints Concerning ILRC's Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing any complaint.

How ILRC May Use and Disclose Health Information About You. This section describes the different ways ILRC may use or disclose your health information. This section identifies those uses and disclosures permitted by federal law without first obtaining from you a specific authorization.

Maintaining the privacy of your health information is very important to us. Again, if you have any questions concerning the attached Notice, please do not hesitate to ask.

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INDEPENDENT LIVING RESOURCE CENTER

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:

Cindi Unruh
Executive Director
3033 W. 2nd
316-942-6300 phone
316-942-2078 fax
1-800-479-6861 voice & TTY
cunruh@ilrcks.org

ILRC is required by law to maintain the privacy of your health information. This Notice describes your rights and certain obligations ILRC and its affiliates have regarding the use and disclosure of health information. It also tells you about the ways in which ILRC may use and disclose health information about you. ILRC is obligated to follow the terms of the notice that is currently in effect.

ILRC is committed to protecting the confidentiality of your health information. This Notice applies to all health information maintained by ILRC.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by ILRC. To inspect and copy your health information, you must complete a specific form providing information needed to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. We may require that you pay such fee prior to receiving the requested copies. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

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Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice.

COMPLAINTS.

If you believe your rights with respect to health information about you have been violated by ILRC, you may file a complaint with ILRC or with the Secretary of the Department of Health and Human Services. To file a complaint with ILRC, contact the person identified on the first page of this Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

HOW ILRC MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

Uses and Disclosures of Protected Health Information Without Your Specific Authorization
ILRC may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your use of ILRC's services.

- ***Payment*** means activities associated with collecting fees for services provided to you by ILRC. Activities associated with payment include, but are not limited to:
  - Collection of fees from agencies
  - Review of payment decisions upon appeal

- ***Health Care Operations*** means
  - Case management and care coordination
  - Contacting you about services
  - Training of non-health care professionals
  - Business planning and development
  - Analysis related to managing and operating ILRC
  - Development or change of payment methods
  - Educational activities

Pursuant to applicable federal law, there are several other uses and disclosures ILRC may make without your specific authorization.

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1. ***Creation of de-identified health information.*** ILRC may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. This would allow analysis of information without the analyst knowing who the data refers to. Once information is de-identified it is no longer protected.

2. ***Furnishing data to Business Associates.*** ILRC's Business Associates (*e.g.*, other agencies, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

3. ***Uses and disclosures required by law.*** ILRC will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

4. ***Disclosures for public health activities.*** We may disclose your protected health information for the following public health activities:
   - To a public health authority that is authorized by law to collect data for the purpose of preventing or controlling disease, injury, or disability.
   - To a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.
   - To a person or business subject to the jurisdiction of the Food and Drug Administration ("FDA") for activities related to the quality, safety, or effectiveness of an FDA regulated product or activity.
   - To a person who may have been exposed to a communicable disease if such disclosure is permitted by law.

5. ***Disclosures about victims of abuse, neglect or domestic violence.*** ILRC may disclose your protected health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence. Such disclosure will be made only (i) to extent required by law, (ii) with your agreement, or (iii) as expressly authorized by statute or regulation.

6. ***Disclosures for health oversight activities.*** ILRC may disclose your protected health information to a health oversight agency for oversight activities. The disclosure must be authorized by law and could include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions. It could also include other activities necessary for appropriate oversight of the system or entities subject to civil rights laws for which health information is necessary for determining compliance.

7. ***Disclosures for judicial and administrative proceedings.*** Your protected health information may be disclosed during any judicial or administrative proceeding if it is:
   - In response to an order of a court or administrative tribunal and includes no more information than that required to satisfy the order;
   - In response to a subpoena, discovery request, or other lawful process not accompanied by an order and the party seeking information has made reasonable efforts to inform you of its actions.

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Right To Request Amendment. If you believe that ILRC's records contain information about you that is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for ILRC. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

We may deny your request for an amendment if you fail to complete the required form in its entirety. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for ILRC;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

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8. ***Disclosures for law enforcement purposes.*** We may disclose your protected health information to a law-enforcement official as required by law or in compliance with:
   - A court order, court-ordered warrant, subpoena, or summons issued by a judicial officer;
   - A grand jury subpoena; or
   - An administrative request related to a legitimate law enforcement inquiry.

9. ***Disclosures regarding victims of a crime.*** In response to a law enforcement official's request, ILRC may disclose information about you without your approval. We may also disclose information in an emergency situation or if you are incapacitated, if it appears you were the victim of a crime.

10. ***Disclosures to avert a serious threat to health or safety.*** We may disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

11. ***Disclosures for specialized government functions.*** ILRC may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

12. ***Disclosures for research purposes.*** ILRC may use or disclose your protected health information for research provided that we obtain documentation that authorization has been waived by either an Institutional Review Board or a privacy board.

Uses and Disclosures Requiring Your Authorization

All other uses and disclosures of your health information will be made by ILRC only with your express written authorization. If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure. Disclosures requiring an authorization include, but are not limited to the following:

1. You want ILRC to disclose information to a family member, close friend, or any other individual (other than a Business Associate of ILRC for the purposes of payment or health care operations).

2. ILRC or a Business Associate of ILRC cannot provide you with marketing materials or disclose your protected health information to any other marketing organization without your authorization.

ILRC reserves the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still using ILRC's services, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, once every three years we will provide you a reminder of the availability of this Notice and how to obtain the Notice.

ILRC POLICY FOR CUSTOMERS & DIRECT SUPPORT WORKER

ADA compliance statement:

The Independent Living Resource Center, Inc. is committed to providing equal access to employment and in all Agency programs, services, and activities to persons with disabilities and fully complies with the American with Disabilities Act and Kansas law.

EQUAL EMPLOYMENT OPPORTUNITY

ILRC believes equal opportunity for all employees is important for the continuing success of our organization. In accordance with state and federal law, ILRC will not discriminate against an employee or applicant for employment because of race, disability, color, creed, religion, sex, age, national origin, ancestry, citizenship, or military status in hiring, promoting, demoting, training, benefits, transfers, layoffs, terminations, recommendations, rates of pay, and all other terms, conditions, and privileges of employment. Opportunity is provided to employees based on qualifications and job requirements. Reasonable accommodations will be made for individuals with disabilities.

PRODUCTIVE WORK ENVIRONMENT

It is the policy of ILRC to promote a productive work environment and not to tolerate verbal or physical conduct by any employee that harasses, disrupts, or interferes with another's work performance or that creates an intimidating, offensive, or hostile environment.

Employees are expected to maintain a productive work environment that is free from harassing or disruptive activity. No form of harassment will be tolerated, including harassment for the following reasons: race, disability, color, creed, religion, sex, age, national origin, ancestry, citizenship, pregnancy, and military status. Special attention should be paid to the prohibition of sexual harassment.

WORKPLACE VIOLENCE/WEAPONS

The possession of firearms, explosives, or other dangerous weapons (including knives with blade lengths above four (4) inches), concealed or unconcealed, on ILRC and consumer property, or while conducting agency business is expressly forbidden.

ATTENDANCE AND PUNCTUALITY

Employees are expected to report to work on time and on a regular basis. Unexcused absenteeism and lateness are expensive and disruptive and place an unfair burden on other employees. Unsatisfactory attendance and punctuality may result in disciplinary action, up to and including termination.

DRUG AND ALCOHOL POLICY

Section 1: Policy

ILRC recognizes that the abuse of alcohol and controlled substances are serious social problems, which can negatively impact the performance and image of employees and ILRC. Therefore, to help ensure a safe, healthy and productive work environment for our employees and others, to protect ILRC property, and to ensure efficient operations, ILRC has adopted a policy of maintaining a workplace free of the use of alcohol and illegal use of controlled substances.

Section 2: General Prohibitions and Restrictions

Individuals under the influence of alcohol and/or the illegal use of controlled substances on the job pose serious safety and health risks not only to themselves, but also to all those who surround or come in contact with the user. Therefore, possessing, using, consuming, purchasing, distributing, manufacturing, dispensing, or selling alcohol or controlled substances, or being under the influence of alcohol or controlled substances without medical authorization during your work hours, on ILRC premises, on an ILRC work site, and/or while on duty, is cause for disciplinary action up to and including immediate termination. Being "under the influence" with regard to alcohol is defined as a blood alcohol content of .04% or greater. Being "under the influence" with regard to a controlled substance is defined as testing positive in a urine or blood test.

ABUSE NEGLECT & EXPLOITATION:

Any suspicion of abuse, neglect or exploitation of any Customer must be reported IMEDIATELY to Adult Protective Services at 1-800-922-5330.

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ILRC COMPLIANCE POLICY

GENERAL

The Independent Living Resource Center requires directors, and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. As employees and representatives of the Independent Living Resource Center, we must practice honesty and integrity in fulfilling our responsibilities and comply with all applicable laws and regulations.

COMPLAINCE OFFICER

The ILRC's Executive Director will act as the ILRC Compliance Officer and is responsible for investigating and resolving all reported complaints and allegations concerning violations and at his/her discretion, shall advise the audit/finance committee. The Executive Director has direct access to the audit/finance committee of the board of directors and is required to report to the audit committee at least annually on compliance activity.

PROVIDING ACCURATE AND COMPLETE DOCUMENTATION

It is the responsibility of all directors and employees to accurately document services provided to ensure that they are medically necessary and properly coded (upcoding, fragmentation, use of inappropriate or outdated codes is unacceptable)

NEGOTIATING AGREEMENTS AND MANAGING RELATIONSHIPS WITH CONTRACTORS AND SUPPLIERS

Statements, communications and representations to prospective partners and suppliers must be accurate and truthful. Contractual obligations must be performed in compliance with the contract. All suppliers should be treated uniformly and fairly. When deciding among competing suppliers, the selections should be based upon objective criteria (including among other factors: quality, technical capabilities, prices, delivery, adherence to schedules, service) and not favoritism. Relationships with contractors and suppliers should be managed in a fair and reasonable manner; consistent with applicable laws and good business practices. Directors and employees may not communicate confidential third party business information given to ILRC by a contractor or supplier without its permission. This ILRC compliance policy will be provided to applicable contractors.

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GIFTS

ILRC directors and employees are not permitted to accept personal gifts. Occasionally, business related gifts or benefits may be accepted if they are of nominal value. Prior to accepting any gift or benefit, the Executive Director should be contacted for guidance. Directors and employees should not give business related gifts without consulting the Executive Director.

ACCURATE BILLING PRACTICES

Billings and claims must reflect that services are supported by relevant documentation and are submitted in accordance with applicable laws, rules regulations and program requirements. Honesty and accuracy in billing and the making of claims to public and private payors is vital. Employees must be alert for and report improper billing to the Executive Director. Improper or fraudulent billing activity may include; cost report falsifications, duplicate billing, multiple coverage and secondary payer fraud, false claims and statements, over billing, billing for services that were not provided, billing for unnecessary services, billing for non- approved treatment or equipment usage, improper coding, (using a billing code that provides a higher payment rate than the billing code which accurately reflects the service provided, upcoding, unbundling, etc.) submitting more than one claim for the same service, non ordered/non performed testing submissions, improper physician or provider referrals (Stark and Anti- Kickback Rules) or certifying or making inaccurate or false statements.

REFERALS

Any business arrangement with a physician or provider must be structured appropriately to ensure compliance with the applicable laws and regulations. ILRC does not pay for referrals and does not accept payment for any referrals that it makes. If a director or employee becomes aware of or is involved with any situation involving bribery, kickbacks, or inappropriate referrals, the director or employee must immediately contact the Executive Director.

CONFLICT OF INTEREST

A conflict of interest may occur if a director's or employee's outside activities or personal interests influence or appear to influence their ability to make decisions for the ILRC. A conflict of interest may also exist if the demands of outside activities or personal interests interfere with the performance of a director or employee's duties for the ILRC. If a director or employee has a question regarding conflict of interest, s/he should consult the Executive Director.

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COMPLIANCE WITH LAWS, REGULATIONS AND GUIDANCE

ILRC, through its directors and employees, will comply with all applicable state and federal laws, regulations and guidance documents. In particular, laws regulations and guidance related to participation in and reimbursements from state and federal public benefit programs will be followed. ILRC will also comply with laws related to anti trust and trade regulations, tax responsibilities, and discrimination in employment or in the provision of services, workplace safety, business practices.

REPORTING RESPONSIBILITY

It is the responsibility of all directors, and employees to report ethics violations or suspected violations in accordance with the Compliance Policy.

REPORTING VIOLATIONS

The Independent Living Resource Center has an open door policy and suggests that employees share their questions, concerns, suggestions or complaints with someone who can address them properly. In most cases, an employee's manager is in the best position to address an area of concern. However, if you are not comfortable speaking with your manager or you are not satisfied with your manager's response, you are encouraged to speak to the Executive Director or anyone in management whom you are comfortable approaching. Managers are required to report suspected ethics violations to the Executive Director who will act as the Compliance Officer and who has specific and exclusive responsibility to investigate all reported violations .. If there is a direct conflict of interest with the situation reported and

Manager, employees are encouraged to report violations to the Executive Director or ILRC Board President.

ACCOUNTING AND AUDITING MATTERS

The audit/finance committee of the board of directors shall address all reported concerns or complaints regarding corporate accounting practices, internal controls or auditing. The Executive Director acting as the Compliance Officer shall immediately notify the audit committee of any such complaint and work with the committee until the matter is resolved.

ACTING IN GOOD FAITH

Anyone filing a complaint concerning a violation or suspected violation must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

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NO RETALIATION
No director, manager or employee who in good faith reports an ethics violation shall suffer harassment, retaliation or adverse employment consequence. An employee who retaliates against someone who has reported a violation in good faith is subject to disciplinary action up to and including termination of employment. This Compliance Policy is intended to encourage and enable employees and others to raise serious concerns within the Independent Living Resource Center prior to seeking resolution outside of the Independent Living Resource Center

CONFIDENTIALITY
Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

EXECUTIVE DIRECTOR/ COMPLAINCE OFFICER
Cindi Unruh
Independent Living
Resource Center
316-942-6300 ext. 222
cunruh@ilrcks.org 3033
W. 2nd Street N.
Wichita, KS 67203

ILRC MANAGEMENT STAFF
Executive Director and Greater Expectations
Manager: Cindi Unruh
316-942-6300 ext. 222

CFO:
Michael Streit 316-942-6300 ext. 229

ILS Manager:
Craig Perbeck 316-942-6300 ext. 210

Rev. 06/15/2015

Kansas
Department of Aging
and Disability Services

Home and Community Based Services
Conflict of Interest Policy – Effective July 1, 2015

KDADS established this policy for the purpose of compliance with Centers for Medicare and Medicaid Services (CMS). It is intended to mitigate conflict of interest that may exist where home and community based Medicaid services are provided. Participants can maintain control of services and conflicts of interest may be mitigate by securing Durable Power of Attorney or separating the "employer of record" from the "manager/worker" and the use of administrative firewalls to separate the two entities.

Consistent with 42 CFR 441.301, the State will ensure policies, processes and protocols are in place to support the person-centered planning process and to mitigate potential conflicts of interest. As a result, KDADS has established the following policy to address potential conflicts:

1. A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflict of interest concerns have been mitigated in accordance with KSA 59-3068.
    a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.
    b. A copy of the special or annual report in which the conflict of interest is disclosed will be provided to the MCO and FMS provider if along with the judge's order approving the annual or special report and determining that there is no conflict of interest for the guardian to be paid to provide supports for the participant under the HCBS program.
2. If the court determines that all potential conflict of interest concerns have not been mitigated, the legal guardian can:
    a. Select someone (family member or friend) to provide the HCBS services to the participant. If a family member or friend is not available, the participant's selected MCO or FMS provider can assist the legal guardian in finding a direct support worker or seeking alternative HCBS service providers in the community; OR
    b. Select someone (family member, friend, non-paid guardian) to appoint as a Designated Representative to develop the integrated service plan and direct the participant's services under HCBS.
3. An activated durable power of attorney (A DPOA who is currently authorized to make financial, medical or other decisions on behalf of the participant) is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual's care (hire, fire, manage, training, and monitor direct support workers).
4. An exception to the criteria may be granted by the MCO when a participant/guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence or the location is so remote that HCBS Program Services would otherwise not be available to the participant if the exception was not granted.

Action Required:

Legal guardians and activated durable powers of attorneys for adults receiving home and community based services must designate a representative to direct the services of an individual the guardian or DPOA represents and provides paid supports to, when a Conflict of Interest exists.

The attached documents define the following:

1. Conflict of Interest
2. Directing Care
3. Appointment of a Designated Representative
4. When an Appointed Designated Representative is required.

The attached forms will be required for the appointment of a Designated Representative and the signed form must be maintained in the individual's service record.

The Designated Representative document will also be posted on the KDADS website for access.

Service Coordinators and Personal agents who identify situations in which a conflict exists must provide the attached information to the individual and the legal guardian to address the conflict.

KDADS recognizes that families as paid care providers are an important part of our service delivery system. The above action allows legal guardians to address conflict of interest, when the legal guardian is chosen by the consumer or representative to be a paid care provider.

Reason for Action: To assure that conflict of interest is addressed when a person directing care on behalf of an HCBS Program participant is proposing to or is providing paid supports to the individual.

Effective Date: This policy is effective as of **July 1, 2015**, following public comment period from April 15th to June 15th. New authorizations for a court-appointed guardian or activated DPOA that wants to be paid to provide supports must be follow this policy effective immediately.

Compliance Date: Court-appointed guardians or activated durable power of attorneys that are currently paid to provide supports and who direct the care of the participant they provide supports to will need to comply with this policy no later than September 30, 2015.

Additional Information: For more information, please visit the Home and Community Based Services Programs pages on the KDADS website at www.kdads.ks.gov or email questions to HCBS-KS @kdads.ks.gov, Subject Line "Conflict of Interest Policy Questions"

KS Dept for Aging & Disability Services
503 S. Kansas Ave
Topeka, Kansas 66603

Phone: 785-296-4986
Fax: 785-296-0256
Email: HCBS-KS@kdads.ks.gov

Kansas
Department of Aging and Disability Services

Designated Representative for Participant-Directed Services

A Designated Representative is defined as a parent, family member, guardian, advocate, or other person who is authorized in writing by the consumer or legal guardian to make determinations on the consumer's assessed care needs, where he or she prefers to live and which home and community based services will be delivered and by whom the services will be delivered. Individuals who chose to participant direct are presumed to have the ability to direct their own care.

Not all individuals receiving home and community based services require a designated representative. A designated representative is only required for individuals with court-appointed guardians (including conservators) or activated durable power of attorneys who are self-directing some or all of the individual's services to mitigate a conflict of interest exists. At no other time will an individual be required to appoint a designated representative. However, an individual may voluntarily decide to appoint a designated representative to perform employer functions related to hiring, firing, monitoring, training and managing direct service workers for participant-directed services

For minor children, legally responsible parent or legal guardian chooses, directs and plans the child's services and will not be required to complete the Designated Representative form. Federal law does not allow a parent or legal guardian of a minor child to be paid to provide services. A parent must comply with requests from the MCO or FMS provider to ensure compliance with federal requirements and establish legal authority.

Conflict of Interest

A conflict of interest exists when the person responsible for developing the integrated service plan to address functional needs is also a legal guardian, durable power of attorney (DPOA) or Designated Representative and that person is also a paid caregiver for the individual. Federal regulations prohibit the individual who directs services from also being a paid caregiver or financially benefitting from the services provided to an individual (42 CFR 441.505).

Therefore, a Designated Representative, activated durable power of attorney, or court appointed guardian shall not also be a paid care provider for the individual, either independently or as an employee or contractor with a provider agency.

In addition, a Designated Representative, activated durable power of attorney, or court appointed guardian shall not also be a Targeted Case Manager for the individual, either independently or as an employee or contractor with a provider agency.

A court appointed guardian or activated durable power of attorney of an adult will, if they are a paid care provider, delegate the authority for directing services to a Designated Representative. The Designated Representative shall not select services for which they financially benefit, such as requiring services be provided through an agency or business that the Designated Representative operates.

To direct services means to determine, based on the assessed needs of the individual, where the services will be delivered and by whom the service will be delivered.

When a court appointed guardian or activated durable power of attorney proposes to or does provide services to the participant, the following actions must be documented in writing and maintained in the individual's service record:

1. A designated representative must be appointed by participant who is directing his or her care or the court-appointed guardian or activated durable power of attorney, if he or she is also a paid care provider. The appointment of a designated representative does not usurp or otherwise change the rights or responsibilities of a court-appointed guardian or as authorized in the durable power of attorney.
    a. The designated representative must be appointed in writing
    b. The appointment shall be at least for the period of the integrated service plan of care, but not to exceed one year.
    c. The appointment will be documented in the individual's integrated service plan, in the individual's file and in the person-centered plan.
    d. The appointment shall be made at least annually or when the designated representative changes.
2. The designated representative will:
    a. Act as the approving agent for services provided, by verifying time and attendance for court appointed guardians or other direct service workers hired to provide services.
    b. Hire, fire, manage, train, and monitor direct service workers, including the paid court-appointed guardian and other direct service workers.
    c. Attend all ISP meetings and represent the individual receiving services for determination of service options and identifying qualified providers.
    d. Attend all Individualized Education Plan (IEP) meetings with the school and individual's support team.
    e. Participate in the person-centered planning process and make appropriate decisions regarding participant-direction.
3. The designated representative will not:
    a. Serve in any other capacity as designated representative for the court appointed guardian.
    b. Displace the guardian in legal and appropriate activities of a court appointed guardian including the appointment of a designated representative.
4. The court appointed guardian, paid to provide services to the individual, may:
    a. Contribute information for the functional needs assessment.
    b. Contribute information for the development of the integrated service plan of care and the person-centered support plan.
    c. Participate fully in the ISP team as a team member.
5. The court appointed guardian, paid to provide services to the individual, may not:
    a. Override team decisions, or contributions of the designated representative.
    b. Determine the hours of service for which he or she will be paid
    c. Determine his or her rate of pay
    d. Sign the integrated service plan of care to authorize services
    e. Serve as the employer of record and hire, fire, direct or manage the other direct service workers.