

**EMPLOYMENT TERMS AND CONDITIONS:**

1. The Participant/Designated Representative has elected to hire me to perform services for them in accordance with the Maryland Department of Health, Developmental Disabilities Administration (Maryland DDA) Self-Directed Services program. I understand that The Arc Central Chesapeake Region (The Arc CCR) is the Fiscal Management Services provider (FMS) who assists the employer with employer-related tasks and *IS NOT* my employer.
2. The Participant or Designated Representative (if applicable) is my employer. The Participant/Designated Representative is responsible for recruiting, hiring, training, managing and supervising me and controlling my workplace activities. The Participant/Designated Representative is solely responsible for the decisions to hire and retain or not retain me.
3. I understand that I am an Employee of the Participant/Designated Representative and am not the Employee of The Arc CCR or the State of Maryland. As a result, I am not entitled to employment benefits issued by The Arc CCR nor the State of Maryland.
4. The Participant/Designated Representative shall set the conditions of employment; termination of employment shall be the prerogative of the Participant/Designated Representative.
5. I understand that the Participant/Designated Representative can immediately dismiss my employment based on any of the following criteria:
  - a. I have been placed on an Employee Disqualification Registry or List,
  - b. I have committed substantiated abuse, neglect, or misuse of funds or property of a Participant receiving services,
  - c. I have committed fraud or violated the terms of this Agreement.
6. I understand that I am an at-will employee. This Agreement does not guarantee me a specific number of hours of work, nor does it limit the Participant/Designated Representative from hiring other Employees under the Self-Directed Services program.
7. This Agreement does not prohibit me from working for more than one Participant/Designated Representative under the Self-Directed Services program.

**ACKNOWLEDGEMENT - I agree to fulfill the following requirements of an Employee of a Self-Directed Services Participant, which shall include the following:**

1. Agree to complete and provide information for a new hire packet, which will include a criminal background screening facilitated by The Arc CCR prior to employment, the results of which may be shared with the Maryland Department of Health - Developmental Disabilities Administration (Maryland DDA) and/or the Participant/Designated Representative for whom I work and their Support Broker, if applicable.
2. Achieve and maintain all training certifications and other requirements as outlined in this application in order to be eligible for payment for services.

3. Know that I am not authorized to begin employment until my new hire document have been completed and submitted in full and the results of the background screening have been received and approved. All new hire documentation must be completed in submitted in full to The Arc CCR and The Arc CCR must provide my employer a notice of clearance to start working. No payments can be provided prior to the date of clearance.
4. Read the Self-Directed Services Employee Handbook and inquire about any aspects requiring clarification, as I will be held accountable for understanding this shared information.
5. Complete and submit timekeeping records and mileage reimbursement forms in a timely manner to my employer for their review and approval; please see The Arc CCR's processing calendars. The Arc CCR will provide payment for services on behalf of the Participant/Designated Representative following the submission of accurate and approved payment requests, within the constraints of the Participant's Person Centered Plan and Budget. I understand that payment will be for typical services rendered as assigned by the Participant/Designated Representative and as outlined in the Participant's Person-Centered Plan and Budget.
6. Carry out all assigned duties and responsibilities explained by the Participant/Designated Representative as outlined in the Participant's Person Centered Plan and Budget.
7. Understand that I can be held liable if I submit fraudulent records that result in over-billing or unjustly billing Medicaid.
8. Cooperate with the Participant/Designated Representative to inform The Arc CCR within 24 hours of the occurrence, in the event that I am injured while providing services to the Participant. I will complete and submit the required worker injury reporting documentation to the Participant/Designated Representative and The Arc CCR in within 48 hours. I understand that I will be covered by workers' compensation insurance and unemployment insurance provided by the Participant/Designated Representative.
9. Recognize that I am a mandated reporter and must immediately report:
  - a. Any suspected Medicaid fraud to the Maryland Department of Health OIG Fraud Hotline at 866-770-7175.
  - b. Any suspected abuse, neglect and exploitation to the appropriate authorities.
10. Notify the Participant/Designated Representative if/when my address or personal information changes or if I wish to change my payment and tax withholding preferences. Those updates must be communicated to The Arc CCR within 5 business days for the purposes of payroll and employee record updates.
11. Contact The Arc CCR directly for my employment verification needs, which may require up to 2 business days for processing.
12. Understand that I am welcomed to and encouraged to communicate with The Arc CCR directly regarding my personnel and payment matters, but that I should do so after advising the Participant/Designated Representative as well.



## Self-Directed Services Employee Agreement

931 Spa Road | Annapolis, MD 21401

Submittal: [FMSNewHirePackets@thearcccr.org](mailto:FMSNewHirePackets@thearcccr.org)

FMS Phone: 1.866.252.6871 | FMS Fax: 1.888.272.2236

### **SIGNATURES:**

By signing below, I attest that I have read and understand the statements outlined on this Acknowledgement and I agree to abide by the terms and conditions of employment by the Participant identified below receiving Fiscal Management Services provided by The Arc Central Chesapeake Region.

Employee Name (please print): \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant (please print): \_\_\_\_\_

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Designated Representative - *if applicable* (please print): \_\_\_\_\_

Designated Representative signature: \_\_\_\_\_ Date: \_\_\_\_\_