LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

FAMILY/LEGALLY RESPONSIBLE INDIVIDUAL (LRI) AS PAID CAREGIVER ATTESTATION FORM

Note: This form uses the term 'beneficiary' to refer to an individual receiving Office for Citizens with Developmental Disabilities (OCDD) home and community-based waiver services.

Beneficiary/Support Coordination/Self-Direction (SD) Employer Information/Authorized Representative
Beneficiary Name: DOB:
Support Coordination Agency Name:
Human Services District/Authority Name:
If Self-Direction, Fiscal Employer Agent Name:
Authorized Representative Name: _____ (If none, enter "N/A" in the blank above) Check all that apply: ☐ Authorized Representative on Plan of Care for Beneficiary ☐ Legally Responsible Individual (LRI) – Parent, Spouse, Curator, Continuing Tutor for Beneficiary ☐ Living with the Beneficiary ☐ Living separate from the Beneficiary
Family as Direct Support Professional/LRI and Provider Agency/SD Employer Information
Beneficiary signature and date: (if a competent major) or Authorized Representative signature if not competent major:
Family Member/LRI as Paid Direct Support Professional (DSP) Name:
Relationship of Family Member/LRI to Beneficiary:

As the Support Coordinator signing this document, I am indicating that I have followed the process for discussion of Best Interest of the Individual, Self-Determination, and Extraordinary Care (LRI only) for the beneficiary listed above and have determined that the Family Member/LRI as Paid DSP listed meets the Best Interest, Self Determination, and Extraordinary Care (LRI only) to be considered to work with the beneficiary as paid staff.

Support Coordinator Signature and Date
Support Coordinator Signature Date

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The family member/LRI being hired to provide paid supports to the beneficiary is required to read and initial all spaces below attesting that they understand and will follow the requirements listed.

_____I understand I must adhere to the health and welfare safeguards identified by the team (the Support Coordinator, family, any professionals involved and anyone the beneficiary wants involved in his/her life), including the application of a comprehensive monitoring strategy and risk assessment.

_____I understand all services that I provide must be documented daily in service notes which describes the services rendered and progress towards the beneficiary's personal outcomes in the plan of care.

_____I understand that I must use the Electronic Visit Verification (EVV) system when my shift starts and ends. If the shift worked is different than what is in the plan of care, I will document why the shift change occurred in the daily service notes.

_____I understand that I am responsible for reporting critical incidents **immediately** to the beneficiary's provider agency/SD employer, including abuse, neglect, and exploitation. Some other examples include, but are not limited to emergency room visits, evacuations, hospitalizations, falls, engagement with law enforcement, etc. (specific requirements are identified in the OCDD Operational Instruction F-5: Critical Incident Reporting, Tracking and Follow-up Activities for Waiver Services).

_____I understand that I am not allowed to work more than 40 paid service hours per week (Sunday to Saturday) as a paid caregiver if I live in the home with the recipient.

_____I understand the beneficiary has individual rights, which must be respected.

_____I understand services provided must be for the beneficiary. I am not allowed to do personal errands or errands for other individuals while "on the clock" for Medicaid when working with the beneficiary.

_____I understand I cannot work another job at the same time I am being paid to care for the beneficiary, nor can I care for other children or adults while I am being paid to care for the beneficiary.

_____I understand that regardless of my relationship to the beneficiary, I may not give any medications or complete non-complex medical tasks for a waiver beneficiary while on shift unless the medication or non-complex task is one that is able to be delegated, and I have been appropriately trained.

_____I understand that, as a paid Direct Support Professional, I must follow the beneficiary's plan of care. This also includes completing any required written documentation.

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_____ I understand that I must adhere to all HCBS policies and procedures for managing the beneficiary's behavior. This includes the following:

- I must not engage in negative disciplinary actions while serving as a paid Direct Support Professional, even though some of the actions may be a part of family disciplinary approaches when the family member is not serving as the paid Direct Support Professional. Some examples include (but are not limited to) requiring the beneficiary to go to a specified location within the home (i.e., a bedroom), taking away something or refusing to allow access to something.

- Prohibited behavior includes the following (Chapter 50. Home and Community-based Services Providers Licensing Standards, Subchapter B. Administration and Organization, 5029. Policy & Procedures):
  - Corporal punishment
  - Restraints of any kind (Note: It is the policy of the OCDD to allow the use of restraints only in response to a situation that represents an imminent and grave risk of injury to the beneficiary or others and at the direction of a treating professional who has considered all other less intrusive options to protect the beneficiary/others. Refer to OCDD Policy #701 Restraint Use in HCBS Services for specific policy requirements and prohibitions.)
  - Psychological and verbal abuse
  - Seclusion
  - Forced exercise
  - Any cruelty to, or punishment of, a beneficiary
    Any act by a provider which denies: food, drink, visits with family, friends, or significant others, or use of restroom facilities (Note: not inclusive of medically prescribed procedures)

- Additional policies and procedures outlined in State Regulations Minimum Licensing Standards LAC 48:1 Chapter 50 and Chapter 51

_____ I attest that I am not the Authorized Representative/Employer for this beneficiary in the Self-Direction program. I understand that I am prohibited from being the Authorized Representative/Employer if I am a paid direct care staff for the beneficiary.

_____ I attest that I have completed the *Family as Paid Caregiver* training **provided by the Provider Agency/SD Employer**, and agree to support and implement the principles identified in the training while providing supports to the beneficiary.

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Signing this document is an attestation that, to the best of my knowledge, the information on this form is true and accurate and I understand the responsibilities of working under the HCBS waiver program as a paid family member living with the beneficiary or the Legally Responsible Individual of the beneficiary. I understand that I will not be allowed to be the paid caregiver for the individual with whom I live, or the individual for whom I am the Legally Responsible Individual if any requirement listed in this attestation is not followed.

Direct Support Professional signature and date:	Last 4 digits of SSN:

As a Provider Agency/SD Employer, I confirm that this individual has viewed the "Family as Paid Caregiver" training. Additionally, I will ensure the requirements in this attestation are followed, and if not, report every occurrence of non-compliance to the Support Coordination Agency, in writing.

Provider Agency Signature or SD Employer signature and date:

The Support Coordination Agency has reviewed this document and all sections are complete.

SCA Signature and date:
Effective Date:

The Support Coordination Agency will forward a copy of this **signed** attestation to the following:

Human Services District/Authority
Provider Agency/Self-Direction Employer
Fiscal Employer Agent (if Self-Direction)
Support Coordination Agency Beneficiary File
LDH Data Contractor (SRI)