LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

SELF-DIRECTION EMPLOYER ATTESTATION FORM

Self-Direction Employer Attestation Form

Self-direction is a service delivery which allows beneficiaries or their Authorized Representative to become the employer of the Direct Support Professionals (DSPs) they choose to hire to provide their supports. As the employer, the beneficiary or their authorized representative is responsible for recruiting, training, supervising and managing their DSPs.

The Authorized Representative/Employer has certain responsibilities for their role in the beneficiary's Self Direction Program and these responsibilities must be fulfilled by the person signing below. (The Authorized Representative/Employer must be 21 years of age or older.) The responsibilities below remain the same whether or not the employer/authorized representative lives in the home with the beneficiary or not. **Under no circumstances should a person sign as the employer if they do not intend to carry out ALL of the responsibilities listed below as they will be held liable if the beneficiary is harmed in the Self-Direction program or if fraud is committed.**

Authorized Representative/Beneficiary Information
Authorized Representative Name:
Beneficiary Name:
Beneficiary Medicaid ID#:
Shared Address:
Address if not Shared:
Fiscal Employer Agent Vendor Information
Fiscal Employer Agent Vendor Name:
Medicaid Provider ID:
Fiscal Employer Agent Vendor Representative Name:

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As the Self-Direction Employer for _____, I am attesting to all of the following (must initial by each section):

_____ I declare that I am at least 21 years of age, live in Louisiana and in close proximity to the participant to be able to carry out all responsibilities.

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

_____I understand all services must be documented in service notes, which describes the services rendered and progress towards the beneficiary's personal outcomes in the plan of care. I understand I must see that the Direct Support Professional (DSP) does this for each shift worked.

_____I understand the Electronic Visit Verification (EVV) system must be used when the DSP starts and ends the established work shift and that if the schedule changes from what is in the Plan of Care daily schedule, it must be documented as to why the change occurred.

_____I understand the beneficiary's Rights and Responsibilities and I will ensure that these rights are respected.

_____I understand critical incidents must be reported within 24 hours to the beneficiary's support coordinator/support coordination agency and any emergency room visits and/or hospitalizations must be reported as soon as possible but within the 24-hour period. Some examples of critical incidents are emergency room visits, evacuations, and hospitalizations.

_____I understand service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home and any hours over this time must not be billed to Medicaid.

_____I understand services must be provided with the beneficiary present. A DSP cannot leave a beneficiary at home while they run errands nor can they run personal errands while "on the clock" working with the beneficiary.

_____I understand DSPs cannot work another job at the same time they are caring for the beneficiary and billing Medicaid nor can they care for other children or adults while caring for the beneficiary and billing Medicaid.

_____ I agree to notify the Department of Children and Family Services/Adult Protective Services/Elderly Protective Services or LAW ENFORCEMENT immediately should any form of abuse or neglect occur.

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_____I understand I am to read the most up to date Self-Direction employer's handbook and to understand the provisions in it. If there is something I don't understand I am to ask questions until I do understand.

_____I understand that, as an employer, my DSPs should not be asked to do any activities that are not directly for the beneficiary, on the plan of care and should not be subjected to harassment in any form, verbal, sexual or other. If problems occur, it is my job to address them immediately.

_____ I understand that I am responsible for reviewing each payroll report to make sure employees are being paid the correct rate for the correct number of hours worked, and there is enough hours in the account to continue receiving paid services for the reminder of the coordinator. I understand I should contact the Fiscal Employer Agent if I do not receive payroll reports.

_____ I understand that I am responsible for approving all time worked by each DSP and that all activities delivered by the DSP meet the requirements outlined in this attestation form.

_____ I understand that I must ensure employee background checks and required screenings are conducted prior to the employee working and at intervals as required in Appendix H of the OCDD Self-Direction Handbook.

_____I understand that if all rules and regulations of the Self-Direction waiver option are not followed, the beneficiary may be asked to leave Self-Direction and choose a provider agency.

_____ I understand that the HCBS Waiver program is funded by State and Federal dollars and at ***any time without advanced notice*** I may be asked to turn over DSP notes and/or records to the **OCDD Monitoring Unit, Louisiana Department of Health's Program Integrity, the Louisiana Legislative Auditor, the United States Department of Justice, and/or the United States Office of the Inspector General's Office.**

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. I understand that falsifying or omitting information may result in an investigation by Medicaid Program Integrity and/or the Louisiana Attorney General's Office or any other state or federal agency with oversight of home and community based services and/or Medicaid funds resulting in jail time and/or a recoupment of paid claims.

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Employer/Authorized Representative Signature:
Beneficiary Signature: (if a competent major)
Fiscal Employer Agent:
Effective Date:

Send completed form to Support Coordinator, Fiscal Employer Agent and Local Governing Entity for their records.

THIS FORM MUST BE SIGNED WHENEVER AN EMPLOYER and/or SUPPORT COORDINATION AGENCY CHANGES and WITH EACH YEARLY PLAN of CARE and WITH A CHANGE OF FISCAL EMPLOYER AGENT.