CalPERS Long-Term Care Program

Independent Provider Acknowledgement of Terms and Release of Liability Form

1. Any employer/employee relationship or contractual relationship concerning the provisions of care is strictly limited to you and the Independent Provider (IP). Neither CalPERS Long-Term Care Program (Program), its Administrator or the assigned Care Advisory Agency is a party to such relationship.

2. Payment for services to the IP is entirely your responsibility, regardless of whether the Program is liable for reimbursement of the claim.

3. Any expenses you incur acting as an employer, which may include any payment of taxes you owe to state, local or federal government in addition to those amounts withheld from an employee's salary are your responsibility. CalPERS does not provide tax advice. Please contact your tax accountant or attorney with any employer tax questions.

4. You are obligated to abide by any local, state or federal laws and/or regulations applicable to this type of relationship.

5. We can offer an Assignment of Benefits to your IP. This means that payment could be made to your IP upon receipt of timesheets and other documentation of the services provided. Please contact your Care Manager if you are interested in this option.

6. A Care Manager must recommend the Plan of Care to be provided, and must remain involved to monitor the appropriateness of the Plan of Care and the IP on an ongoing basis. The Program reserves the right to terminate approval of a Plan of Care at any time if the Care Manager determines that use of any IP is no longer appropriate.

7. The Care Manager is available to consult with you regarding any quality of care issues. Notwithstanding this provision, you, as the employer or as the manager of the service contract, are solely responsible for the quality of care provided. The Program and its Administrator have no liability regarding the acts or omissions of you or the IP.

8. You are responsible for the completion of this packet and the submission of all required documentation for our review. Required documents include, but are not limited to:

    - Original, not copied, timesheets. These timesheets must be filled out completely.

    - Proof of payment in the form of:
        - Original or copies of cancelled checks that are written to the IP that would include the specific dates of service that are applicable for the charges in the memo portion of the check. (If copies, they must be processed by your financial institution and include both the front and back of each check.);
        - Electronic funds transfer statements;
        - Credit card transaction statements;
        - Payroll service statements;
        - Copy of the live cashier's check that is written to the IP (**before cashed by the IP**) that would include the specific dates of service that are applicable for the charges in the memo portion of the check; or

- Copy of the live money order that is written to the IP (**before cashed by the IP**) that would include the specific dates of service that are applicable for the charges in the memo portion of the order.

We recommend you make copies of all the information you submit to the Program including weekly timesheets and proof of payment.

I have read and understand the above Independent Provider Acknowledgement of Terms and Release of Liability:

_____ _____

Signature of Claimant or Claimant's Representative Date signed (Month, Day, Year)

_____

Claimant or Claimants Representative Name (Please Print)

_____

If Representative, give relationship to Claimant

Claimant Name: _____ Coverage ID: _____

Independent Provider Timesheet Instructions

Please enter a check mark or "X" mark for each activity when Substantial Assistance is provided for each date of service. Substantial Assistance is defined as: either Hands-on Assistance or Standby Assistance. Hands-on Assistance is the physical assistance of another person without which you would be unable to perform the Activities of Daily Living. Standby Assistance means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, your injury while you are performing the Activities of Daily Living**.**

Each Activity of Daily Living is defined below. Leave the section blank for the activities for which no assistance was provided.

Activities of Daily Living

Bathing
Cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing and drying.

Dressing
Putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

Toileting
Getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning body after toileting, and using and emptying bedpan and urinal.

Transferring
Moving from one sitting or lying position to another sitting or lying position (e.g., from bed to or from a wheelchair or sofa), coming to a standing position and/or repositioning to promote circulation and prevent skin breakdown.

Continence
Ability to control bowel and bladder as well as use ostomy and/or catheter receptacles and apply diapers and disposable barrier pads.

Eating
Reaching for, picking up, grasping a utensil and cup; getting food on a utensil, bringing food, utensil and cup to mouth; and manipulating food on plate; and cleaning face and hands as necessary following meal. **(Note: This Activity of Daily Living is not related to meal preparation or grocery shopping.)**

Other Personal Cares

Medication Administration
Substantial assistance with the administration of medication.

Walking/Mobility
Substantial assistance with walking or moving around outside or inside the place of residence, changing locations in a room, or moving from room to room to gain access for the purpose of engaging in activities.

Continual supervision needed due to a cognitive impairment with the above aspects of walking/mobility.

Homemaker Services Incidental to Personal Care
Domestic or cleaning services, laundry services, or meal preparation and cleanup, transportation, reasonable food shopping and errands or transportation assistance to and from medical appointments. (Changes for mileage, taxi, or chauffer services or other similar charges are not covered.)

Severe Cognitive Impairment

Supervision to ensure safety: Applicable only when the claimant has a severe cognitive impairment

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to and includes Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to people, places or time and deductive or abstract reasoning.

Severe Cognitive Impairment requires continuous supervision or oversight by another person to protect from threats to health or safety (including, but not limited to, prevention of falls, wandering, ensure nutritional and hydration needs are met, etc.).

Independent Provider (IP) Personal & Professional History

This form must be submitted completely and accurately filled out for the Program to consider this Provider under the Alternative Care Payment Provision.

Claimant Name: _____ **Coverage ID:** 41-_____

Independent Provider information; please include a copy of a government-issued photo ID.

Name: _____ Phone: (_____)_____

Address: _____

City: _____ State: _____ Zip Code: _____

Tax ID or Driver License Number_____

Is this IP related to you? ☐ Yes ☐ No If yes, what is the relationship? _____

Please check those that apply:

This IP is a friend: ☐ Yes ☐ No This IP is a neighbor: ☐ Yes ☐ No

This IP is my significant other: ☐ Yes ☐ No This IP is an ex-spouse: ☐ Yes ☐ No

Does this IP hold Power of Attorney or other legal authorization to act on your behalf?
☐ Yes ☐ No If yes, please describe: _____

Does this IP live in your home? ☐ Yes ☐ No
If yes, please advise when did the IP move in? Date: _____

Is this IP currently receiving Social Security Disability Income or any other disability benefits or income?
☐ Yes ☐ No If yes, please describe _____

Is this IP employed by anyone other than/in addition to you? ☐ Yes ☐ No If yes, by who – Please advise name and phone number of other employer: _____

Does this IP provide assistance or service to anyone else in your household? ☐ Yes ☐ No
Please explain: _____

Is this IP able to physically assist you with your Activities of Daily Living? ☐ Yes ☐ No If no, please provide details._____

When did the IP start providing service for you? Date: _____

Training/Education/Skills- A copy of licensure or certification **must** be included.
Type of license/certification: _____

Insured: ☐ Yes ☐ No (*if yes, please enclose copy)* Expiration date: _____

Bonded: ☐ Yes ☐ No (*if yes, please enclose copy)* Expiration date: _____

Describe pertinent education or skills: (reference checks are recommended; please attach)

_____
_____
_____
_____

Claimant Name: _____ **Coverage ID:** 41-_____

Schedule: Which days per week will the IP work? Advise all days that IP will provide services and indicate what hours will be worked in the following table.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time In (Specify AM/PM)							
Time Out (Specify AM/PM)							
Total Hours Per Day							

What is the rate per hour you will be paying this IP? (Daily and weekly rates are not accepted.) $_____

Do you intend to withhold any payment of taxes owed to state, local or federal governments? ☐ Yes ☐ No

If yes, does the rate per hour above include the taxes owed to state, local or federal governments? ☐ Yes ☐ No

Why do you want to hire this person as your IP? _____

_____

_____

Please advise if someone, other than the claimant, will be managing the IP

Name: _____ Phone: (_____) _____

Address: _____ Relationship: _____

City / State / Zip: _____

Power of Attorney or Conservatorship information must be submitted for the individual named above.

I hereby certify that the information provided above is true and correct to the best of my knowledge.

Signature of Claimant or Representative: _____ Date: _____

Signature of Independent Provider: _____ Date: _____

Choosing an Independent Provider

The following are a few suggestions of where you might try looking for a qualified provider:

- **Home care registry or employment agency:** Usually listed in the yellow pages of your local phone book, these agencies may already have screened the applicants and may charge a finder's fee or monthly service charge.

- **Churches/synagogues:** They often have community bulletin boards, newsletters, senior groups or other programs that may be a referral source.

- **Newspaper advertisements:** The best bet is to place an ad in your local community paper.

- **Community colleges, vocational/technical schools:** Schools that offer nursing classes and training in the home health aide/nurse's aide occupations often are excellent referral sources.

An in-person interview is a crucial part of the selection process. Before you start interviewing people for the job, you may wish to develop a list of the tasks the provider will be expected to perform and your expectations as an employer.

Suggested Interview Questions:

- What interests you about this job?
- Tell me about your current and past home care experiences.
- Why did you leave your last job?
- What would you do in case of an emergency such as (I) fall?
- What salary and benefits are you looking for?
- What days and during what time of day are you available?
- What qualifications and training do you bring to this job?

While interviewing the person, observe for the following:

➔ Is this a personality I think I can work with?
➔ Do they appear to have the attributes needed to do the job, i.e. do they look like they can transfer me if needed?
➔ Can I communicate easily with this person?

References, Training, Education & Skills

Attached is an IP Personal and Professional History form that we are requesting you complete and forward to us for each provider you plan to request to be reimbursed under your plan.

Reference checks are a critical step when selecting an employee, since this individual will be in your home. The more you know of their background and qualifications the better able you will be to select a competent employee who can be entrusted to provide care. It is recommended you call and check at least two personal or professional references.

Suggested Reference Questions:

- How long did this person work for you?
- How long have you known this person?
- Why did they leave your employment?
- Were they reliable when they worked for you, did they arrive on time, leave on schedule?
- How was their attendance while employed for you? Did they call when they were not able to work, etc.?
- Would you rehire this person?
- Would you recommend this person for a job in home care?

After you have selected your candidate, you may wish to express your expectations to your employee(s) regarding the following (Note: The following are suggestions for your personal use in employing an Independent Provider and do not change or expand the definition of covered services under your Long-Term Care Plan):

- Schedule: days needed, hours needed
- Rate of pay, method of payment
- Payday
- Car fare, gas reimbursement or mileage
- Illness/ absences
- Paid vacation, holidays, make-up time
- Emergencies or reimbursement in the event you are hospitalized
- Meals, food and/or housing provided
- What to do in case of an emergency
- Record keeping
- Supervision procedures
- Taxes
- Notice or termination of employment

INDEPENDENT PROVIDER WEEKLY TIMESHEET

Client Name: _____

Coverage ID: 41-_____

Provider Name: _____

Provider Address: _____

Provider Phone: _____

Mail or fax this form to:
The Calpers Long-Term Care Program
P.O. Box 64902
St. Paul, MN 55164-0902
Phone: (800) 982-1775
Fax: (866) 294-6967

INSTRUCTIONS: Please submit a separate weekly time sheet for **each** Independent Provider. A column must be completed for each day of provided services with the hours worked and dollars paid for each day documented. Enter a check mark for each activity when either **hands on or standby** assistance is provided. Please refer to the instructions for further information.

***Date** (indicate under each day):*	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time In (specify am/pm):							
Time Out (specify am/pm):							
Activities of Daily Living (Hands On or Standby Within Arms Reach):							
Bathing							
Dressing							
Toileting							
Transferring							
Incontinence care							
Eating (feeding – not meal prep)							
Supervision to Ensure Safety due to a Cognitive Impairment							
Other Personal Cares:							
Medication Administration							
Ambulation Assistance, Including Walking							
Homemaker Services:							
Meal Preparation							
Laundry							
Housekeeping							
Transportation							
Hours Worked:							
Dollars Paid:							

General Comments/Observations/Changes in condition or services explanation of weekly charge not matching proof of payment (please add additional pages as needed):

☐ Check this box if you are withholding employee taxes. Please indicate weekly amount withheld. _____ Sum of withholding and proof of payment must equal the weekly charge.

Please note: ***For your protection, some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial penalties may be imposed.*** *If we determine that benefits have been paid under this coverage as a result of your fraudulent action(s), we have the right to recover those benefit amounts. We may recover those benefit amounts directly from you or by reducing any subsequent benefit payments under this coverage. We will determine that manner in which we seek recovery of benefit payments made under fraudulent conditions****. In New York, the penalty shall be a fine not to exceed $5,000 and the stated value of the claim for each such violation.***

Total hours worked this period:
(equals the hours from Sun-Sat) _____ **Hourly rate:** _____ **Total Weekly Charge:** _____

I declare that all of the above information is complete and true to the best of my knowledge. I understand that the «grp_program» reserves the right to require additional documentation in support of this claim.

Claimant / Representative Signature: _____ Date: _____

Independent Provider Signature: _____ Date _____

The timesheet is not to be signed until the work week has been completed and all weekly services have been recorded.