COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF AGING

CAREGIVER SUPPORT PROGRAM

Conditions of Participation - Certificate of Accountability

I, _____, Primary Caregiver, for _____, Care Receiver, certify all information I have provided during assessment and throughout my enrollment in the Caregiver Support Program is true and accurate to the best of my knowledge. I agree to comply with all program requirements. I understand this document will serve as an agreement between myself and the Area Agency on Aging (AAA) and may be used as a basis for the recovery of reimbursements if I am determined to be in violation of this agreement.

My signature indicates I understand, and agree with, the following terms and conditions of the Caregiver Support Program:

- I have assumed the primary responsibility for the provision of care needed to maintain the physical and/or mental health of this Care Receiver and am actively involved with all aspects of the Care Receiver's care on a regular, but not necessarily daily, basis.

- I understand I may not receive reimbursement for personally providing caregiving services to my Care Receiver.

- I understand I may not receive reimbursement of costs associated with the payment for caregiving services provided to my Care Receiver by relatives.

- I certify I have **never**:

    - been convicted of a crime relating to abuse, neglect, exploitation or abandonment
    - been found civilly liable for abuse, neglect, exploitation or abandonment
    - been notified I am an alleged perpetrator in a substantiated report of need for protective services under The Older Adults Protective Services Act, The Adult Protective Services Act or The Child Protective Services Act.

- I understand this is not an entitlement program. Reimbursement is based on my needs in support of my Care Receiver, income eligibility and availability of funds.

- I understand I have the right to appeal decisions made by the AAA regarding program eligibility or the denial, termination or reduction of services.

- I agree to annually provide financial information for the Care Receiver's household. I agree to provide additional information if requested.

- I understand if I enter into an agreement or arrangement with an individual(s), party or entity to assist in the provision of care or respite to my Care Receiver, I assume all risks associated with said care arrangement and hold harmless the AAA from any and all claims, liabilities and costs related to the agreement or arrangement with the individual(s), party or entity to provide care to the Care Receiver.

- I understand all purchases must be approved in advance by my Care Manager and must be directly related to the specific needs of my Care Receiver. I will provide documentation for all expenses for which reimbursement is being requested.

- I understand I cannot be reimbursed for general supplies that may be used by others within the household (i.e., toilet paper, shampoo, soap, etc.).

- I understand my calculated reimbursement percentage will be applied to the receipts submitted to determine the amount that I will be reimbursed.

- I understand I have the ability to accumulate reimbursement benefits for use at a later date and prior to use of these benefits, a plan approved by my Care Manager must be in place. Accumulated benefits (used for planned absences, such as an extended respite) can only be accumulated for a six-month period and cannot be carried past June 30th of each calendar year.

- I understand reimbursement for pre-approved home modifications and assistive devices (up to a lifetime maximum of $5000) will be subject to my calculated reimbursement percentage and will depend upon the availability of funds.

- I understand the deadline for submission of monthly receipts is by the ____ of the month following the month in which the purchase was made. I agree to abide by such deadlines and submit receipts accordingly. I understand that failure to submit receipts by the deadline will result in denial of reimbursement and continuous failure to submit receipts by the deadline may result in disenrollment of the program.

- It is my responsibility to report to my Care Manager any changes in the status of my caregiving situation. Reportable changes include, but are not limited to, significant changes in the health status of my Care Receiver, living arrangements, household income, my ability to provide necessary care, and the availability of informal supports.

- By receiving services under the program, I am subject to administrative actions and penalties if I perform one or more of the following acts:

    - Making a false statement or causing a misrepresentation of a material fact regarding information affecting eligibility for benefits.
    - Submitting false or fraudulent documentation of caregiving expenses, for which reimbursement is sought or received.
    - Refusal to provide requested documentation for eligibility.

If I violate this agreement, the Area Agency on Aging has the authority to suspend or terminate services. If I receive reimbursement for which I am ineligible, the Agency may recover twice the amount of reimbursement determined to be appropriate, plus interest. The Agency also has the ability to initiate legal proceedings.

Primary Caregiver Signature	Date
Care Manager Signature	Date