

**VendorFiscal/Employer Agent (VF/EA)  
Financial Management Services (FMS)**

**COMMON LAW EMPLOYER AGREEMENT FORM**

I understand that participating in the VF/EA FMS model means that the Common Law Employer (CLE) has the ability to exercise decision-making authority over some or all of the Participant's services and supports as authorized in the person-centered Individual Service Plan (ISP). The Common Law Employer (CLE) accepts responsibility for managing the Participant's service and supports and is, therefore, recognized as the legal employer of the qualified Direct Care Workers (DCWs) hired to provide the Participant's person-centered Participant Directed Services (PDS).

**PARTICIPANT'S INFORMATION:**

Name of Participant Receiving PDS: (Print/type) \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (Unit/Apt.)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Home Phone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell Phone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

E-mail Address: \_\_\_\_\_

**PARTICIPANT'S EMERGENCY CONTACT INFORMATION:**

Name of Emergency Contact: (Print/type) \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (Unit/Apt.)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Home Phone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell Phone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

E-mail Address: \_\_\_\_\_

**COMMON LAW EMPLOYER: (CHECK ONE BOX)**

Participant  Designated Common Law Employer

If the Participant designates an alternative common law employer, complete the information on the next page.

**Designated Common Law Employer Information (if applicable):**

Name: (Print/type) \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (Unit/Apt.)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Home Phone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell Phone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

E-mail Address:  
\_\_\_\_\_

The Participant or Designated CLE, when appointed by the Participant, must meet the following criteria in order to be the CLE:

**Common Law Employer (CLE) Requirements and Responsibilities:**

1. Be at least 18 years of age or older.
2. Complete all forms in the employment forms package and return the completed forms to your VF/EA FMS.
3. Make decisions about the best way to meet your needs, receive and use goods and services and then judge how those goods and services worked for you, making changes as needed.
4. Collaborate with your Service Coordinator (SC) to develop your Individual Service Plan (ISP) based on your medical, social, functional and educational needs and goals.
5. If enrolled in budget-authority model of service, determine how your individual budget will be spent by developing your spending plan. Use your individual budget responsibility; your spending plan must reflect your assessed service needs identified in your ISP.
6. Recruit, hire, manage and dismiss your DCWs.
7. Train your DCWs in providing services that are described and authorized by your ISP.
8. Establish a mutually agreeable schedule for the DCW that meets your needs.
9. Decide how much to pay your DCW within the OLTL established wage limits and authorize their paychecks by reviewing and signing timesheets.
10. Provide your DCW with feedback to let them know if they are doing things the way you want.
11. Submit all approved purchases, invoices and timesheets to your VF/EA FMS.
12. Demonstrate the required skills and abilities needed to self-direct DCWs without jeopardizing your health and safety, or designate a representative to assist you.
13. Develop and implement a back-up plan.
14. Participate in required training sponsored by OLTL or your VF/EA FMS.
15. Contact your SC to request a new assessment or to change your spending plan as your needs and goals change.
16. Secure qualified vendors.
17. Verify the qualification of DCWs and vendors prior to the person or entity rendering a waiver-funded participant-directed service and complete ongoing qualifications as needed according to waiver requirements.
18. Notify your SC and your VF/EA FMS when you suspect or are aware of issues of Medicaid fraud or financial abuse related to the delivery of participant-directed services.

## COMMON LAW EMPLOYER ATTESTATION

By signing below, I \_\_\_\_\_ attest that I have read  
(Name of Common Law Employer)

this *Common Law Employer Agreement* in its entirety.

- I understand that I must complete, sign and return this form to the VF/EA FMS organization under contract with the Office of Long-Term Living (OLTL) as a condition of enrolling and participating in the VF/EA FMS model.
- I attest that I understand my responsibilities as a CLE and agree to abide by the CLE terms and conditions.
- I further understand and agree that violation of any of the terms and/or conditions of this Agreement may result in corrective action including termination of this Agreement and termination of the Participant from the VF/EA FMS model.

\_\_\_\_\_  
(Common Law Employer Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)