

## West Virginia Personal Options Intellectual/Developmental Disabilities Waiver Program Enrollment Form

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Name of Representative (optional) \_\_\_\_\_

Representative Phone \_\_\_\_\_

Your Public Partnerships LLC (PPL) resource consultant is available to help you with the responsibilities of directing your own services. Your resource consultant (RC) is a support and will be there to help you understand and manage your program responsibilities. Your resource consultant will also help you monitor your health and safety through a monthly phone contact. The information below covers important program responsibilities.

**I understand I am responsible for:**

- Electing the participant-directed option
- Working with my resource consultant to become oriented and enrolled in the Personal Options program, enrolling Qualified Support Workers (employees), developing a spending plan for the participant-directed budget, and creating an emergency back-up plan to ensure staffing
- Revising my spending plan, as needed, and working with my resource consultant to ensure my needs are covered for the entire budget year
- Recruiting, screening, training, hiring, and supervising my employees
- Verifying qualifications of my employees and other service providers
- Determining my employee's schedules and how/when they should perform required tasks
- Notifying my employees 24hrs in advance if services are not needed
- Verifying hours worked and services provided by my employees and other providers
- Requesting payment for other goods and services as needed
- Payment of goods and services that exceed my allocated amounts or are not in my approved spending plan. Goods and services may not exceed \$1,000.00 per budget year
- Refunding Public Partnerships in full in the event of overpayment for goods and services
- Maintaining documentation in a secure location and ensuring employee confidentiality
- Discharging my employees when necessary and submitting a Separation of Employment form

- Communicating any problems with services to my Public Partnerships resource consultant
- Reporting any suspected fraud to my Public Partnerships resource consultant and/or the West Virginia Medicaid Fraud Unit at 304-558-1858
- Reporting any incidents of abuse, neglect, or exploitation to my Public Partnerships resource consultant and/or the Department of Health and Human Services (DHHR) Adult Protective Services or Child Protective Services Hotline at 1-800-352-6513
- Reporting any suspected illegal activity to my local police department or appropriate authority
- Notifying my service coordinator and resource consultant of any changes in service needs and any hospitalizations

**I understand the following:**

- I am a household employer of domestic employees under West Virginia Labor law
- My employees must pass an initial criminal background check through WV Cares before providing services and every five years thereafter
- My employees must pass an initial screening of the Office of Inspector General exclusions list and every month thereafter
- My employees must complete all initial training requirements before providing services and annually thereafter and will not be paid if not kept current
- I cannot receive Personal Options services while I am in an ICF/IID, rehabilitation facility, hospital, or nursing home
- Public Partnerships will not pay for services if either my financial and/or medical eligibility for IDD Waiver services expires. In the event services were paid, I am responsible for refunding Public Partnerships in full
- Public Partnerships will not pay for services performed out of state. Consult with your resource consultant regarding rules for those living in counties that border another state

**I agree to:**

- Comply with IDD Waiver and Personal Options program requirements. I understand I will be removed from Personal Options if I disregard these requirements
- Permit representatives of BMS, KEPRO, and Public Partnerships to enter my home as scheduled
- Be present for scheduled appointments

**I understand I have the right to:**

- Appoint a representative to assist me if desired
- File complaints and grievances with Public Partnerships and/or KEPRO
- Transfer my participant directed services back to traditional agency services if desired

**I agree to notify PPL immediately if:**

- My phone number or address changes
- My employees are no longer employed by me
- I am admitted to a hospital, rehabilitation facility, ICF/IID, or nursing home
- I am found medically or financially ineligible for IDD Waiver services
- My employee or representative forces me to continue Personal Options even though I am not getting the assistance I need

**Voluntary Consent to Enroll**

By signing below, I certify that I understand and agree with all the above responsibilities and choose to voluntarily enroll in Personal Options.

**Signatures**

\_\_\_\_\_  
**Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Representative (optional)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness (Required if signed with mark)**

\_\_\_\_\_  
**Date**