



Living Independently in Northwest Kansas

2401 E. 13th St. Hays, KS 67601
(785) 625-6942 (V/TT) (785) 625-6137 FAX

FINANCIAL MANAGEMENT SERVICES AGREEMENT

(Between Consumer/Employer and LINK, Inc.)

THIS FINANCIAL MANAGEMENT SERVICES AGREEMENT, Made and entered into as of this _____ day of _____, 20____, by and between LINK, Inc., a Kansas corporation, with its registered office at Hays, Kansas, hereinafter referred to as “the FMS Provider,” and, _____, a qualified individual, or his/her representative, who has chosen to self-direct his/her direct care services in accordance with his/her Plan of Care (Integrated Service Plan) pursuant to the Vendor Fiscal/Employer Agent (F/EA) Model adopted and authorized by the State of Kansas, hereinafter referred to as “the SDI” (Self Directing Individual) and the SDI retains the responsibility as the common law employer.

WITNESSETH:

WHEREAS, FMS Provider has entered into and currently holds: (1) a Provider Agreement with appropriate state agencies and (2) a Medicaid Provider Agreement with the Kansas Department For Aging and Disability Services (KDADS) and (3) the Managed Care Organization (MCO) for the provision of Financial Management Services in the State of Kansas; and

WHEREAS, FMS Provider is authorized and provides Financial Management Services to qualified individuals, or their representatives, who have chosen to self-direct their direct care services in accordance with their Plan of Care (POC/ISP) pursuant to the Vendor Fiscal/Employer Agent Model adopted and authorized by the State of Kansas as well as the MCO; and

WHEREAS, the SDI desires to retain the services of FMS Provider to provide Financial Management Services for the SDI, including but not limited to those services selected by the SDI from the list of services described on Exhibit “A” which is attached hereto and by reference made a part hereof, and such other and further Financial Management Services as may be requested from time to time by the SDI, and the FMS Provider desires to provide the Financial Management Services to and for the SDI on the terms and conditions hereinafter set forth; and

WHEREAS, the parties hereto desire to enter into this Agreement to set forth the terms and conditions under which the selected Financial Management Services will be provided by the FMS Provider for the SDI:

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants hereinafter set forth, the parties hereto hereby agree as follows:

1. **RETENTION OF SERVICES:** The SDI hereby agrees to retain the FMS Provider to perform the Financial Management Services, and the FMS Provider hereby agrees to perform the Financial Management Services for the SDI for a term commencing on _____, 20____, and continuing until terminated in the time and manner hereinafter set forth.

2. **COMPENSATION:** As compensation for the services to be rendered by the FMS Provider hereunder, FMS Provider shall receive the Per Member per Month (“PMPM”) compensation from the State of Kansas or MCO.

3. **SELF DIRECTING INDIVIDUAL “SDI” DUTIES AND RESPONSIBILITIES:** The SDI (and or his/her representative if applicable) has been informed and understands that he/she has the RIGHT, but not the obligation, to elect to participate

in the F/EA FMS employer-option and that having elected to participate in the employer-option he/she has the RIGHT to choose from qualified available FMS Providers.

The SELF DIRECTING INDIVIDUAL "SDI" (and or his/her representative if applicable), also have been informed and understands that he/she has the RIGHT and RESPONSIBILITY to:

- (A) Choose and direct support services;
- (B) Choose and direct the workers who provide the services;
- (C) Perform the roles and responsibilities as the employer;
- (D) Understand the roles and responsibilities of the FMS Provider;
- (E) Receive initial and ongoing skills training as requested.

Attached hereto as Exhibit "B" and by reference made a part hereof and incorporated herein is a list of the RESPONSIBILITIES of the SDI (and or his/her representative if applicable).

3. **FMS PROVIDER DUTIES:** FMS Provider shall devote such time, energy, and ability in providing the Financial Management Services to the SDI consistent with the self-directing alternatives that are available to and selected by the SDI in compliance with applicable governmental statutes, rules, and regulations, Provider Service Agreement requirements, Medicaid Provider requirements, as well as the MCO's and other applicable policies and procedures related to providing Financial Management Services to the SDI. **As part of this agreement, the SDI is requesting Workman Compensation on all employees they hire, regardless of relationship.** [REDACTED] (employer initials)

The SDI, or his/her representative, shall select those Financial Management Services which he/she desires to be provided by FMS Provider by marking the desired Financial Management Services on Exhibit "A" to this Agreement.

By signing below, the SDI, or his/her representative, consent to and authorize the FMS Provider to use the electronic document system to the extent and as it deems necessary or appropriate.

In providing the Financial Management Services hereunder, the FMS Provider shall comply with applicable governmental statutes, rules, and regulations, Provider Agreement requirements, Medicaid Provider requirements, as well as the MCO's and other applicable policies and procedures related to providing Financial Management Services to eligible beneficiaries.

4. **TERMINATION:** The relationship described herein and the rights and obligations provided with respect thereto shall be for a term commencing as of _____, and shall terminate upon the earlier occurrence of any of the following events:

- (a) The written agreement of the parties hereto to terminate their relationship; or
- (b) If FMS Provider ceases to exist or be authorized to do business or perform the Services hereunder; or
- (c) Upon thirty (30) days prior written notice from either party; or
- (d) Upon the occurrence of a material breach of this Agreement, or substantial failure of either party to perform their respective duties and responsibilities set forth above; or
- (e) In the event that funding of the PMPM is not available, curtailed, or substantially reduced by the State of Kansas or MCO.

5. **CONTROL:** The SDI as the employer, or his/her representative, shall have control over the nature and extent of the Financial Management Services to be provided. In addition, the SDI, or his/her representative, shall have control over and be responsible for the selection, schedules, tasks to be performed, management, and related payroll type activities of his/her assigned Direct Support Worker. The SDI, or his/her representative, may recruit and refer his/her preferred Direct Support Worker to FMS Provider: (a) to be included in FMS Provider's pool of Direct Support Workers; (b) for background and qualification checks and verifications in compliance with applicable governmental statutes, rules, and regulations, Provider Service Agreement requirements, Medicaid Provider requirements, and other applicable policies

and procedures related to Direct Support Workers; (c) for orientation and training; and (d) completion of payroll and related forms and documentation.

_____ (employer initials) As the employer, I agree to pay out of pocket for any hours my DSW works above the approved POC/ISP. I understand the reimbursement rate from the MCO only covers the hours approved on my POC/ISP and it is my responsibility to verify time worked and to stay within the approved POC/ISP.

_____ (employer initials) As the employer, I understand my DSW will receive payment for hours above the approved POC/ISP on the payroll following the FMS agents receipt of my payment.

_____ (employer initials) As the employer with an POC/ISP over 40 hours a week, I am choosing to negotiate a lower rate of pay with my DSW to cover the cost of overtime if I choose not to hire another DSW to perform the support services I need. The rate must be at least minimum wage, and if there is not enough state reimbursement to cover these costs I am responsible for all money owed above what the state reimbursement rate will cover.

6. INDEPENDENT CONTRACTOR: FMS Provider is an independent contractor and, agrees to assist in obtaining and maintaining an employer identification number with the Internal Revenue Service and to comply with all tax laws applicable to the operation of its business, including, but not limited to, the reporting of all gross receipts therefore as income from the operation of a business, the payment of all self-employment taxes, compliance with all employment tax requirements for withholding on any employees used by a self-directing individual contracting with Independence, Inc. FMS, and compliance with state employment and workmen's compensation laws.

7. SEVERABILITY: All agreements and covenants contained herein are severable, and in the event any such agreement or covenant shall be held to be invalid by any competent court, this Agreement shall be interpreted as if such invalid agreement or covenant was not contained herein.

8. COUNTERPARTS: If this Agreement is executed in counterparts, each shall constitute an original and all together shall constitute one agreement. Signed facsimile and pdf versions of this Agreement shall be treated as originals and shall be fully binding on and enforceable against the parties.

9. GOVERNING LAW AND BINDING EFFECT: This Agreement shall be governed by and construed in accordance with the laws of the State of Kansas, and shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, executors, administrators, personal representatives, successors, and assigns.

IN WITNESS WHEREOF, the parties have hereunto set their hands on the day and year first above written.

“FMS PROVIDER”
LINK, Inc.
A Kansas Corporation

By: _____

“SELF DIRECTING INDIVIDUAL”/”Employer”

By: _____
Printed Name

By: _____
Signature

EXHIBIT "A"

AVAILABLE FINANCIAL MANAGEMENT SERVICES

FOR SELECTION BY SELF DIRECTING INDIVIDUAL

- Ensure the beneficiary/employer or beneficiary's representative, rather than the FMS provider, have the right to choose, direct, and control the services and DSW's who provide them without excessive restrictions or barriers except as required by Medicaid program requirements
- Provide all human resource services including but not limited to: Obtain authorizations to conduct criminal background checks, child abuse, and adult registry checks in accordance with applicable waiver requirements. Collect and process all required federal, state, and local forms required for employment and the production of payroll
- Help the self-directing beneficiary/employer set the correct pay rate for each DSW as allowed under the procedures set by the State of Kansas or MCO
- Provide and maintain all Payroll processing and records in compliance with federal and state labor laws, for DSW's, this will include but is not limited to: meeting all federal, state, and local wage and tax filing, and workers compensation coverage
- Will notify the self-directing beneficiary/employer of any changes to the time submitted by the DSW's due to non-compliance of the approved Plan of Care
- Maintain an Internal Quality Assurance program that monitors: Self-directed beneficiary's satisfaction, DSW's satisfaction, correct approval/submission of DSW's time worked, correct payroll distribution
- Maintain all records/processes according to each waivers requirements
- Assist the self-directing beneficiary/employer or beneficiary's representative with DSW's with Information and Assistance such as skills training, communication skills, and problem solving. The extent of the assistance furnished to the self-directing individual will be determined by the self-directing individual/employer or the beneficiary's representative

EXHIBIT "B"

SELF DIRECTING (Employer) INDIVIDUAL'S DUTIES AND RESPONSIBILITIES

- Act as the employer for the DSW or designate a representative to manage or help manage the DSW's
- Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the beneficiary and the FMS provider
- Select the direct support worker(s) (DSW's)
- Refer the DSW's to the FMS provider for completion of required human resources and payroll documentation
Note: In cooperation with the FMS provider, all employment verification & payroll forms must be completed
- Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties, including rate of pay
- Provide or arrange for appropriate orientation and training of the DSW's
- Determine the schedules of the DSW's
- Determine the tasks to be performed by the DSW's and where and when they are to be performed in accordance with the approved and authorized POC/person-centered support plan (PCSP)/Attendant Care Worksheet (ACW)/Customer Service Worksheet (CSW and/or others as identified and applicable to each specific waiver
- Manage and supervise the day-to-day HCBS activities of the DSW's
- Verify and approve the time worked by the DSW's was delivered according to the POC/ISP
- Ensure submission of required DSW documents to the FMS provider for processing and payment in accordance with the established FMS, state, and federal requirements Note: The documentation must reflect actual hours worked in accordance with an approved POC/ISP
- Report work-related injuries incurred by the DSW's to the FMS provider agency staff immediately
- Develop an emergency worker backup plan in case a substitute DSW is ever needed on short notice or as a backup (short-term replacement worker)
- Develop an emergency back-up plan for natural disasters
- Ensure all appropriate service documentation is recorded as required by the State of Kansas HCBS waiver program policies, procedures, or by the Medicaid Provider Agreement
- Inform the FMS provider of any changes in the status of DSW's such as a change of address or telephone number, in a timely fashion
- Inform the FMS provider of the dismissal of a DSW within three working days
- Inform the FMS provider and care coordinator (case manager) of any changes in the status of the beneficiary or beneficiary's representative, such as the beneficiary's address, telephone number , or hospitalizations, within three working days
- Participate in required quality assurance visits with case managers, state Quality Assurance staff, state quality management specialist (QMS), or other appropriate and authorized reviewers/auditors



LINK, Inc.

EMERGENCY INFORMATION

NAME: _____ D.O.B. _____

DISABILITY: _____

EMERGENCY CONTACT

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____, _____

PHONE: _____ (HOME) _____ (CELL)

BUSINESS ADDRESS: _____

BUSINESS PHONE: _____

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____, _____

PHONE: _____ (HOME) _____ (CELL)

BUSINESS ADDRESS: _____

BUSINESS PHONE: _____

DOCTOR: _____ Phone: _____

HOSPITAL: _____ Phone: _____

ALLERGIES: _____

Other: _____

Consent to Use and Disclose Health Information

I have selected LINK, Inc. as my Center for Independent Living and/or Financial Management Service (FMS) Provider. I give permission to LINK, Inc. to use and disclose protected health information to carry out treatment, payment, or health care operations necessary to assure my continued eligibility for this service. I received a Notice of My Rights to the Protection of Individual Health information. I reviewed this Notice prior to the signing of this consent. LINK, Inc. reserves the right to amend the Notice and I have a right to request and review the amended Notice. I understand my right to request restrictions regarding the use or disclosure of individual health information in the carrying out of treatment, payment, or health care operations. If LINK, Inc. agrees to my restrictions then the restrictions are binding upon LINK, Inc. However, I also understand that LINK, Inc. does not have to agree to my requested restrictions. I understand my right to revoke in writing this consent, except to the extent that LINK, Inc. and other covered entities have taken action in reliance upon it.

I understand that LINK, Inc. may release protected health information for use in a directory, disclosure to family or my designated persons and for fund raising or advocacy before the State or Federal government. I have been given the opportunity to object to any of these uses by placing a check mark next to the following statements:

- I do not want limited information released to a third party.
- I do not want information disclosed to family members or persons who ask for me.
- I authorize LINK, Inc., to disclose information about me to the person or persons listed on an attached piece of paper.
- I do not want information used to raise funds.

LINK, Inc. will protect my anonymity by using or disclosing the minimum amount of information necessary for the purpose.

_____	_____
Consumer	Date
_____	_____
LINK, Inc. staff	Date

**State of Kansas
National Voter Registration Act of 1993
Agency Declination Form**

Are you registered to vote where you live now?

Yes (If Yes, list County you are registered to vote in) _____

If you are **NOT** registered to vote, would you like a voter registration application sent to you?

Yes No

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

IF YOU DO NOT ANSWER EITHER QUESTION, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek help or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Kansas Secretary of State
2nd Floor, State Capitol
300 SW 10th Street
Topeka, Kansas 66612-1594

If you decline to register to vote, that fact will remain confidential and will be used for voter registration purposes only.

If you do register to vote, the name of the office where you submit your application will be confidential and will be used for voter registration purposes only.

Name of Applicant

Signature

Date

HANDBOOK ACKNOWLEDGEMENTS

I, _____, have received, read and reviewed with LINK, Inc. personnel the Consumer Handbook. If I am an FMS Consumers, I have also read and reviewed the Financial Management Services Handbook and Successful Self-Direction of Direct Support Workers Handbook, and I verify that:

- 1) I am a person with a disability.
- 2) I understand the contents of the handbooks and my rights and responsibilities as a consumer and/or employer as I participate in the LINK, Inc. Program.
- 3) I have received a copy of the Client Assistance Program (CAP) Brochure.
- 4) (FMS Consumers only) I understand that I am the employer of my Direct Support Worker.
- 5) I understand that after my case has been classified as inactive, LINK, Inc. will retain my records for a period of ten years at which time they will be destroyed, unless I claim them.

Consumer	Date
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LINK Personnel	Date
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I would like to receive the LINK, Newsletter by mail: Yes _____ No _____



CONFIDENTIAL INFORMATION

Living Independently in Northwest Kansas

2401 E. 13th St. Hays, KS 67601
(785) 625-6942 (V/TT) (785) 625-2334 (FAX)

PLEASE FILL OUT THIS FORM AND RETURN TO ADMINISTRATIVE ASSISTANT FOR INFORMATIONAL PURPOSES ONLY

Name Last First Middle

Phone Home Cell

Address Street City State Zip

Birthdate Age

Submission of information about a disability is VOLUNTARY but desired. This form will be placed in your file.

Check the following:

Sex: Male Female

Marital Status: Single Married Divorced Widowed

Race/Ethnic Group: White Black Hispanic American Indian/Alaskan Native Asian/Pacific Islander

Referral Source: Friend State Agency Advertisement. If so, where? Other (Specify)

Consumer Printed Name _____

CM Initials _____



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REQUEST/WAIVER FOR ADDITIONAL SERVICES

LINK staff can also provide you with the following services:

INFORMATION AND REFERRAL: We can assist you in locating and identifying appropriate supports and services to remain living independently in your home and community. We collaborate with other agencies within the communities to find the best fit for you.

INDEPENDENT LIVING SKILLS TRAINING: We help you attain knowledge and skills that you need or desire to become and remain independent.

PEER SUPPORT: We share our experiences and/or knowledge or link you with someone who can relate to the changes and challenges that you might be facing.

ADVOCACY:

Individual Advocacy: We will assist you in advocating for yourself. We can also act as an advocate to resolve access, service, or integration issues with others. This includes special education, education, housing issues, etc.

Systems Advocacy: Our advocates work collaboratively with you, staff, business leaders, politicians, and other organizations to improve access, service and integration for all people with disabilities.

TRANSITION SERVICES: We will assist you in moving out of a nursing facility, institution or restrictive environment into your own home.

PLEASE CHOOSE ONE OF THE RESPONSES BELOW:

YES, I am interested in working on one or more of the above items with an Independent Living Specialist.

Consumer Signature

Phone Number

No thank you, I am NOT interested in developing an Independent Living Plan at this time, or receiving any additional services from LINK, Inc. other than my FMS Services, but understand that, should I change my mind, LINK can provide these services to me.

Consumer Signature

Date

Goals to Work on:



- 1: _____
- 2: _____
- 3: _____



REFERRAL

NAME: _____ PHONE: _____

ADDRESS: _____ DOB: _____

TOWN, ST, ZIP: _____ SOCIAL SEC #: _____

E-MAIL ADDRESS _____ INCOME \$ _____

INSURANCE: _____

SEX: _____ ETHNICITY : _____

MARITAL STATUS: _____ EMPLOYMENT: _____

DISABILITY: _____

DCF _____ REFERRAL SOURCE: _____

SERVICES REQUESTING: _____

IN HOUSEHOLD _____ PETS: # _____ DOGS # _____ CATS

REFERRED TO: _____ DATE: _____

BY: _____

Initial Contact: (3 tries/different times): _____

(Must be within five business days return to referral source if unable to contact)

Scheduled Appointment Date and Time: _____

Original Referral to Records upon completion.