fello. SELF-DIRECTED SERVICES

# Employee Agreement

Direct: 1.866.252.6871 | Fax: 1.888.272.2236
Submittal/Questions: SDSNewHirePackets@fello.org
Open a Customer Service Ticket: felloselfdirection.zendesk.com
Website: fello.org/selfdirectedservices

## EMPLOYMENT TERMS AND CONDITIONS:

1. The Participant/Representative has elected to hire me to perform services for them in accordance with the Maryland Department of Health, Developmental Disabilities Administration (Maryland DDA) Self-Directed Services program. I understand that Fello is the Self-Directed Services provider (SDS) assisting the employer with employer-related tasks and *IS NOT* my employer.
2. The Participant or Representative (if applicable) is my employer. The Participant/Representative is responsible for recruiting, hiring, training, managing and supervising me and controlling my workplace activities. The Participant/Representative is solely responsible for the decisions to hire and retain or not retain me.
3. I understand that I am an Employee of the Participant/Representative and am not the Employee of Fello or the State of Maryland. As a result, I am not entitled to employment benefits issued by Fello nor the State of Maryland.
4. The Participant/Representative shall set the conditions of employment; termination of employment shall be the prerogative of the Participant/Representative.
5. I understand that the Participant/Representative can immediately dismiss my employment based on any of the following criteria:
    a. I have been placed on an Employee Disqualification Registry or List,
    b. I have committed substantiated abuse, neglect, or misuse of funds or property of a Participant receiving services,
    c. I have committed fraud or violated the terms of this Agreement.
6. I understand that I am an at-will employee. This Agreement does not guarantee me a specific number of hours of work, nor does it limit the Participant/Representative from hiring other Employees under the Self-Directed Services program.
7. This Agreement does not prohibit me from working for more than one Participant/Representative under the Self-Directed Services program.

## ACKNOWLEDGEMENT

**I agree to fulfill the requirements of an Employee of a Self-Directed Services Participant, which shall include, but is not limited to, the following:**

1. Agree to complete and provide information for a new hire packet, which will include a criminal background screening facilitated by Fello prior to employment, the results of which may be shared with the Maryland Department of Health - Developmental Disabilities Administration (Maryland DDA) and/or the Participant/Representative for whom I work, their Coordinator of Community Services (CCS) and their Support Broker, if applicable.
2. Achieve and maintain all training certifications and other requirements as outlined in this application in order to be eligible for payment for services.

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3. Know that I am not authorized to begin employment until my new hire document have been completed and submitted in full and the results of the background screening have been received and approved. All new hire documentation must be completed in submitted in full to Fello and Fello must provide my employer a notice of clearance to start working. No payments can be provided prior to the date of clearance.
4. Read the Self-Directed Services Employee Handbook and inquire about any aspects requiring clarification, as I will be held accountable for understanding this shared information.
5. Complete and submit timekeeping records and mileage reimbursement forms in a timely manner to my employer for their review and approval; please see Fello's processing calendars. Fello will provide payment for services on behalf of the Participant/Representative following the submission of accurate and approved payment requests, within the constraints of the Participant's Person-Centered Plan and Budget. I understand that payment will be for typical services rendered as assigned by the Participant/Representative and as outlined in the Participant's Person-Centered Plan and Budget.
6. Carry out all assigned duties and responsibilities explained by the Participant/ Representative as outlined in the Participant's Person-Centered Plan and Budget.
7. Understand that I can be held liable if I submit fraudulent records that result in over-billing or unjustly billing Medicaid.
8. Cooperate with the Participant/Representative to inform Fello *within 24 hours of the occurrence*, in the event that I am injured while providing services to the Participant. I will complete and submit the required worker injury reporting documentation to the Participant/Representative and Fello *within 48 hours*. I understand that I will be covered by workers' compensation insurance and unemployment insurance provided by the Participant/Representative.
9. Recognize that I am a mandated reporter and must *immediately* report:
    a. Any suspected Medicaid fraud to the Maryland Department of Health OIG Fraud Hotline at 866-770-7175.
    b. Any suspected abuse, neglect and exploitation to the appropriate authorities.
10. Notify the Participant/Representative if/when my address or personal information changes or if I wish to change my payment and tax withholding preferences. Those updates must be communicated to Fello within *5 business days* for the purposes of payroll and employee record updates.
11. Contact Fello directly for my employment verification needs, which may require up to *3 business days* for processing.
12. Understand that I am welcomed to and encouraged to communicate with Fello directly regarding my personnel and payment matters, but that I should do so after advising the Participant/Representative as well.

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**SIGNATURES:**

**By signing below, I attest that I have read and understand the statements outlined on this Acknowledgment and I agree to abide by the terms and conditions of employment by the Participant identified below receiving Self Directed Services provided by Fello.**

Employee Name (please print): _____

Employee signature: _____ Date: _____

Participant (please print): _____

Participant signature: _____ Date: _____

Representative – *if applicable* (please print): _____

Representative signature: _____ Date: _____