GOVERNMENT OF THE
DISTRICT OF COLUMBIA
DEPT OF HEALTH CARE FINANCE
LONG-TERM CARE ADMINISTRATION

Services My Way

AGREEMENT TO RECEIVE PDCS AND PCA

Date:_____

Participant Name: _____

Common Law Employer Name (*if different from Participant*)**:** _____

Home Health Care Agency (HHA): _____

This agreement may only be completed by participant/employers that have successfully completed the Services My Way enrollment process or have been approved and have a current and active budget.

I have been approved for _____ Personal Care Aide (PCA) hours per week. I agree that _____ hours should be provided by the above identified Home Health Agency (HHA) and _____ hours be provided under the Services My Way (SMW) program. I understand that the number of combined hours cannot exceed my total number of approved PCA hours.

I agree and understand the following:

- ☐ I will not authorize my Participant Directed Worker (PDW) to provide Participant Directed Community Supports (PDCS) at the same time as my PCA that is provided by my approved HHA.
- ☐ If I exhaust my SMW budget, my HHA will not be responsible for providing the hours identified in my budget. This will require the use of my unpaid emergency back-up and/or natural supports. I will also be referred to the Remediation, Training and Termination Protocol.
- ☐ This agreement will be included as a part of my Person-Centered Service Plan (PCSP) and SMW Participant/Employer file.
- ☐ I will notify my Support Broker, Case Manager, and HHA if I would like to modify this agreement to change the number of approved number of hours provided by SMW or my HHA.
- ☐ I will not begin the PDCS and PCA service hours outlined in this agreement until the date of the latest required signature on this agreement.
- ☐ I will not make any changes in the way my services are being delivered in this agreement until a new agreement is signed by all parties. A new SMW budget must be created consistent with the new agreement that includes the update to my PDCS hours.

I agree and understand that a new attestation is needed when:

- ☐ My HHA has changed.
- ☐ My number of approved PCA hours changed.

Attestation

By signing below, I attest, as the Participant/ Representative – Employer, that, I have read this Services My Way and Personal Care Aide Agreement in its entirety and understand the information included in this agreement.

I understand that I must sign and return this Agreement (and retain a copy for my personal records) as a condition to receive both Participant Directed Community Supports (PDCS) in the Services My Way program and PCA with a Home Health Agency (HHA). I further attest by signing the below that I understand what is being required of me and agree to abide by its terms and conditions.

_____ _____
Signature of Participant/Employer *Date*

By signing the below, I attest, as the Case Manager, that the approved PCA hours are current and correct. I further attest, that I will include this agreement with the Person-Centered Service Plan (PCSP) and will only request a Prior Authorization for PCA hours that are included in this approved agreement.

_____ _____
Signature of Case Manager *Date*

By signing the below, I attest that _____ HHA has accepted this case and will only provide the number of agreed on hours approved in this agreement.

_____ _____
Signature of Accepting HHA *Date*

_____ _____
Signature of DHCF or DHCF Designee *Date*

This form is not complete without all four dated signatures.