Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

☐HBCW
☐SCL
☐ABI

Kentucky Consumer Directed Option
Employee/Provider Contract

I (*employee name*) _____, have agreed to work

under the employment of (*employer name)* _____.

Services under this contract will consist of the following:

Services	Total Approved Hours Per Month	Rate Per Hour

Services Available Through the Consumer Directed Option

Respite (*HCB, SCL, and ABI*)
Personal Care (*HCB and ABI*)
Homemaker (*HCB only*)
Attendant Care (HCB only)
Companion Services (ABI only)
Community Living Supports (SCL only)
Adult Day Training (SCL only)
Supported Employment (SCL only)

I agree to provide the above listed services as required by my employer at the rate stated above per hour. I will not exceed the total approved amount noted above.

I accept the check(s) as payment in full for the service(s) or items purchased. I will not make additional charges to or accept additional payments from the consumer(s).

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers

Compensation (KRS Chapter 342) shall not apply to my employment as a Consumer Directed Option provider. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor service advisor can be held liable for any injuries or losses I may incur while providing services.

I understand that I may not be approved as a CDO provider if my background check detects that I have pled guilty to or been convicted of committing a sex offense or a felony offense.

I understand that I may not be approved as a CDO provider if my name is listed on the Kentucky Nurse Aide abuse registry.

I understand that I must maintain employee/employer confidentiality.

I understand this is an at-will contract and either party may terminate this agreement at any time.

I understand that I must notify my employer of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

I have received any and all training required by my employer in order to provide the necessary services as described in this contract.

I agree to follow all relevant state and federal statutes and regulations.

I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer and myself.

_____		_____	
Employee/Provider	Date	Employer/Member	Date