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| **Participant Name:** |  |

**Direction of Services (Choose one)**

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| I choose to **self-direct** my *STEPS* personal attendant services. I understand that I will be the Employer of Record. I understand that this means I will be responsible for hiring, training, scheduling, and firing of my staff. | I choose **agency-direction** for my *STEPS* personal attendant services. I understand that I will not have the responsibility of hiring, training, scheduling, and firing of my staff. I understand that the agency I choose will be responsible for these functions. |
| I choose a **combination** of self-direction and agency-direction for my STEPS personal assistance services. | |

**Representative (Choose one)**

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| I will **make my own** decisions regarding my *STEPS* services. No one else will be making decisions on my behalf. | I **choose**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to act as my personal representative. This person can/will help me make decisions regarding my *STEPS* services in an unpaid capacity. |
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| Signature | Date |

**Reporting Abuse, Neglect, Exploitation, and Fiduciary Abuse**

**Definitions:**

"Abuse" means any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a participant, including:

* Infliction of physical or mental injury;
* any sexual act with an individual when the individual does not consent or when the other person knows or should know that the individual is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship;
* unreasonable use of physical restraint, isolation, or medication that harms or is likely to harm an individual;
* unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the punishment, for the individual or another person;
* a threat or menacing conduct directed toward a participant that results or might reasonably be expected to result in fear or emotional or mental distress to a participant;
* fiduciary abuse; or
* omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

**"Neglect"** means the failure or omission by one's self, caretaker or another person with a duty to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

**"Exploitation"** means misappropriation of participant property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

**"Fiduciary abuse"** means a situation in which any person who is the caretaker of, or who stands in a position of trust to, a participant, takes, secretes, or appropriates the participant's money or property, to any use or purpose not in the due and lawful execution of such person's trust.

**Reporting**I understand that my Community Services Coordinator and MCO Care Coordinator are required by Kansas law to report concerns if they feel I am being abused, neglected, exploited, or subject to fiduciary abuse.

I understand that I may report if I am being abused, neglected, exploited, or experiencing fiduciary abuse to the Department of Children and Families Adult Protective Services Kansas Protection **Report Center   
at 1-800-922-5330** (Telephone lines are staffed 24 hours a day.)

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| Signature | Date |

**Participant Rights**

* Participants have the right to information that will assist them in making an informed choice regarding whether they want to enroll in *STEPS*.
* Participants have the right to timely enrollment in *STEPS*.
* Participants have the right to a person-centered planning process with all aspects of *STEPS*, including the assessment, development of the Individualized Service Plan and Individualized Emergency Back-Up Plan, and completing the Participant Agreement form.
* Participants have the right to have the assistance of a representative, family, friends, or Community Services Coordinator with all aspects of *STEPS* mentioned above.
* Participants have the right to self-direct their services their personal care attendant services. KDHE does reserve the right, however, to require Participants to have a family member, representative, or agency direct their services if there are concerns about the ability to self-direct their services.
* Participants are required to have criminal background checks conducted on their personal assistance providers.
* Participants have the right to file a grievance with the MCO regarding *STEPS* services, or appeal actions taken by the MCO to KDHE.
* Participants have the right to report abuse, neglect, and exploitation to DCF.

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| Signature | Date |

**Participant Responsibilities**

* Participants are responsible for complying with *STEPS* program policies and procedures as laid out in the *STEPS* Program Manual. Note: Participants unwilling to follow these program policies and procedures will be required to leave the program.
* Participants have the responsibility to provide eligibility staff, in a timely and complete manner, with all paperwork needed to complete annual eligibility and six-month desk reviews, without a disruption in services.
* Participants are responsible for paying their Working Healthy premium monthly by the date specified on their statement (if applicable).
* Participants have the responsibility to obtain all necessary information to enable them to make an informed choice regarding whether they want *STEPS* services.
* Participants have the responsibility to be available for their initial assessment, and annual re-assessments, at the date and time agreed upon.
* Participants have the responsibility to accurately report their need for services during the *STEPS* assessment. NOTE: Falsifying the needs for services will result in removal from the program and be reported to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU).
* Participants have the responsibility to ensure that the services and costs listed on their Individualized Service Plan reflect the needs identified during their *STEPS* assessment.
* Participants have the responsibility to complete an Individualized Emergency Back-Up Plan that ensures adequate coverage in the event that their employees do not come and indicates that they have made provisions for their safety in the event of a natural or any other form of disaster.
* Participants have the responsibility to sign all sections of the Participant Agreement form, indicating the informed choices they have made, as well as their willingness to comply with the *STEPS* program policies and procedures.
* Participants are responsible to understand and accept the responsibilities and risks of directing their own care, as well as having knowledge of their rights, or designating a representative who understands their needs and is willing to accept the responsibilities and risks of directing their care; or choosing a state licensed Home Health agency, CDDO or Affiliate Agency willing to direct care on their behalf.
* Participants have the responsibility to complete all of the paperwork required by the FMS provider in a thorough and timely manner to ensure that their PAs and providers are paid in a timely manner.
* Participants have the responsibility to verify time worked by approving time sheets. Falsification of time sheets, either by the Participant or PA, will result in removal from the program and will be reported to the MFCU.
* Participants have the responsibility to submit timesheets in the timeframe identified by the FMS provider.
* Participants have the responsibility to inform eligibility staff when they are no longer employed, and to contact their Benefits Specialist to set up a Temporary Unemployment Plan if they want to remain in *STEPS* for a “grace” period of up to four months.
* Participants have the responsibility to communicate any changes in status, needs, problems, etc. to the appropriate DCF, KDHE, or MCO staff.
* Participants have the responsibility to inform their MCO Case Manager or Community Services Coordinator in a timely manner if they wish to return to an HCBS waiver or waiver waiting list.

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| Signature | Date |

***Note: Inappropriate use of Medicaid funds is considered Medicaid fraud, will be reported to the Office of the Attorney General Medicaid Fraud Control Unit, and may result in prosecution.***

**Civil Rights**

No person shall, on the grounds of race, color, national origin, age, disability, religion, or sex, be excluded from participation in, be denied the benefits of or be subject to discrimination under any program or activity of the Department for Children and Families or Kansas Department of Health and Environment.

**Signature Page:**

I have read and understood this entire choice/consent form. I understand that I get to receive a copy of this choice/consent form for my records.

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|  |  |
| Participant Signature | Date |
|  |  |
| Representative/Guardian Signature | Date |
|  |  |
| CSC Signature | Date |