LAKELAND CARE
Together, we build better lives.

Service Addendum:
Financial Management Services - Self Directed Supports

The provision of contracted, authorized, and provided services shall be in compliance with the provisions of this agreement, the service description and requirements of this section and, if applicable, state certification and licensing criteria.

Section 1. Service Definition and Description

Self-Directed Supports (SDS) Financial Management Services are services to assist members and their families to manage service dollars to prevent institutionalization. This service includes a person or agency paying the member's workers after the member or legal decision maker authorizes payment to be made for services included in the member's approved SDS plan.

Financial Management Services (FMS) Providers, sometimes referred to as fiscal intermediaries or fiscal agents, are organizations or individuals who pay personnel costs, tax withholding, worker's compensation, health insurance premiums, and other taxes and benefits as indicated in the individual's SDS plan.

Financial management services are purchased directly by the MCO and made available to the member or legal representative to ensure that appropriate compensation is paid to their workers.
A FMS Provider must have standards in place that ensure, at minimum, that the Provider:

1) Is an agency, unit of an agency or individual, that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include SDS,
2) Has training and experience in accounting or bookkeeping; and,
3) Has a system in place that recognizes the authorization of payment by the participant or legal decision maker, that promptly issues payment as authorized, and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal decision maker.

Specific to SDS, Financial Management Services is a service/function that assists the member to:

1) Manage and direct the distribution of funds contained in the member-directed plan;
2) Facilitate the employment of staff by the member by acting as the member's agent and performing such employer responsibilities as ensuring adherence to training and documentation standards for supportive home care staff per Home and Community Based Waiver, processing payroll, withholding, and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; purchasing and managing a worker's compensation policy on behalf of the member; and,

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3) Performing fiscal accounting and making expenditure reports to the member and state authorities

   The FMS Provider shall generate employee payroll checks and non-labor related invoices in a timely and accurate manner and in compliance with all federal and state regulations pertaining to domestic/household employees and independent contractors. The FMS Provider will also be responsible for documenting and reporting on all disbursements to the state, LCI, and members.

Fiscal/Employer Agent (F/EA) is when the member is considered the legal employer of staff. The FMS Provider establishes the member as a legal employer by obtaining an Employer Identification Number (EIN) for the member and helping the member complete necessary documents, including federal and state tax forms. The member signs a form that allows the FMS Provider to file employer taxes on his/her behalf. Employees whom the member has chosen to hire are subject to a pre-employment background check and, if hired, must complete certain employment documents, including the W-4 and I-9 forms. Members are responsible for recruiting, hiring, training, supervising and, if necessary, dismissing their employees.

Some of the responsibilities of the member as employer include:

1) Recruiting and selecting employees to be hired.
2) Setting employees' work schedules and wages within appropriate limits, following wage and hour laws
3) Deciding how to train employees
4) Choosing and managing the tasks assigned to employees.
5) Supervising employees while they perform tasks for the member, providing feedback regarding employees' performance of these tasks and, if necessary, dismissing employees
6) Signing employee timecards and submitting them to the FMS Provider as authorization for payment of wages

Agency with Choice (AWC) is when the member manages employees but is not the employer. The FMS Provider is the legal employer and the member shares some of the employer responsibilities. The FMS Provider is responsible for the paperwork requirements, worker's compensation, and liability insurance coverage. Some of the responsibilities shared by the member include:

1) Recruiting and recommending employees to be hired
2) Assisting with setting employees' work schedules and wages within appropriate limits, following wage and hour laws
3) Helping guide training of employees
4) Choosing and managing the tasks assigned to employees.
5) Supervising employees while they perform tasks for the member, providing feedback regarding employees' performance of these tasks and, if necessary, making the decision to dismiss employees (the FMS Provider notifies employees if they are being terminated).
6) Signing employee timecards and submitting them to the FMS Provider as authorization for payment of wages

Fiscal Conduit (FC) is when the member purchases a service or goods from an independent contractor, company, or organization of their choice using a SDS plan that is developed and authorized based on what LCI would otherwise pay through a contracted provider. The entity from which the service or goods are purchased invoices the FMS Provider and provides a completed Form W-9 Request for Taxpayer Identification Number and Certification to the FMS Provider. The FMS Provider issues payment for the service or goods and a 1099 Form to the entity from which the service or goods were purchased.

Staff to Member Ratio
Staff to member ratio for services will vary based on member needs and long-term care outcomes and will be determined under the guidance of the LCI IDT staff.

Scope of Service:
Enrollment and Orientation

1) Upon receiving referral information from LCI, the FMS Provider will contact the member/legal decision maker, within 3 business days, to schedule an initial face-to-face enrollment and orientation visit with the member and each potential employee. Communication of the scheduled enrollment and orientation visit will be made to the LCI SDS Specialists and the LCI IDT staff, as IDT staff may attend this visit.
2) During the enrollment and orientation visit, the FMS Provider will:
    a. Use LCI's preferred terminology:
        i. Financial Management Services (FMS) provider
        ii. SDS employee (*potential* SDS employee until hired)
    b. Confirm receipt and satisfactory completion of employment application form and Background Information Disclosure (BID); ensure completion of all other necessary employment documents: W-4, I-9, etc.
        i. The FMS Provider must have each potential employee complete all Federal and State required employment documents prior to beginning any employment.
    c. Educate both the member and the potential SDS employee that they may not start working – and will not be paid for any work performed prior to IDT staff giving the member the definite start date.
        i. This is contingent upon a review of background check findings (which may result in additional discussion with the member if there are concerns), the assignment of the SDS worker Medicaid ID, and the satisfactory completion of specific documents by both the member and the potential SDS employee
    d. Confirm with the member what their authorized service(s) are and what wage is for each potential SDS employee, as authorized on the referral form
    e. Explain the timesheet completion and submission process:
        i. What the SDS employee completes and signs
        ii. What the member reviews and signs

iii. Whether the member is delegating the review/signature to another person.
iv. How the completed and approved timesheet is submitted to the FMS Provider
v. When the timesheets are due each pay period
vi. How and when paychecks are distributed to SDS employees

f. Discuss Medicaid fraud with both the member/legal representative and what to do if Medicaid fraud is suspected
g. Educate member and potential SDS employee(s) on Electronic Visit Verification (EVV) and provide training on chosen device
h. Explain the Provider's portal and/or reports that the member will receive for monitoring adherence to the established SDS Plan

3) The FMS Provider is responsible for processing all background checks for potential employees. Completed background checks must be emailed to LCI's IDT staff, IDT Supervisor, and SDS Specialists.
   a. If an employee has had a clean background check completed within 6 months of becoming hired through a different member, the previous background check results can be used, unless there is reason to believe there is a change. The member or LCI IDT staff may still request that a new background check be obtained.
   b. If an employee has had a background check with results completed through a different member, LCI requires a new background check be obtained, no matter the length of time since the employee was hired.
4) The FMS Provider must report on the status of any open referrals to LCI's SDS Specialists on a, at minimum, weekly basis until the referrals are processed.
5) The FMS Provider will retain copies of the referral forms in the agency file as proof of authorization.

*LCI funds cannot be released without completion of all required employment paperwork, including background checks, and SDS worker assignment of a Medicaid ID.

On-Going Monitoring

1) The FMS Provider will provide ongoing support for members and their employees.
2) The FMS Provider will provide ongoing education and support for EVV compliance.
3) The FMS Provider agrees to perform in-home visits, as needed or requested, during the contract year to assist members and/or employees with FMS-related functions.
4) The FMS Provider will oversee and monitor the members' SDS plan.
5) The FMS Provider will immediately communicate, via written communication (email) or telephone, to LCI's IDT staff and SDS Specialists when the Provider

identifies any suspicious or irregular spending by the member, which may include:

a) A sudden deviation from what the member typically submits for timesheets
b) A 25% or greater utilization of hours approved per pay period
c) A drastic rate of pay change to the employee not authorized within the SDS plan
d) Timesheets that do not appear to be aligned with the approved SDS plan
e) An overlap in billable time by employees
f) Inaccurate timesheets, including only billing one code when there are multiple codes authorized
g) A deviation in the timesheet signatures
h) Frequent, manual changes to timesheets right before submission
i) Submission of time during known ineligible periods (i.e. hospitalizations, short-term nursing home stays, when member is at day services, etc.)

6) The FMS Provider will provide supporting documentation (timesheets, payroll history reports, etc.) to LCI staff as requested to aid in collaborative and effective care management practices.
7) The FMS Provider will submit a monthly spending report to LCI's SDS Specialists and to the member.
    a) The monthly spending reports will always include monthly utilization details (authorized hours vs. billed hours) and will flag or identify the percentage of any monthly overutilization.

Section 2. Rate Setting and Billable Units

Through the use of the Resource Allocation Decision method (RAD), the LCI IDT staff shall assess the member's needs and outcomes to determine the amount of services to be authorized. The LCI IDT staff shall exchange pertinent information with the FMS Provider at the time the referral is made to assure all health and safety needs are provided for during the services. This exchange of information shall include the assessed needs and amount of authorized units as it relates to services.

All aspects of services shall be discussed between the LCI IDT staff, member or legal representative, and FMS Provider to ensure proper collaboration.

The LCI team will provide a written referral form to the FMS Provider agency which specifies the expected outcomes, amount, frequency and duration of services.

Provider rates for provision of services will incorporate all administrative and business functions related to the provision of service. Contracted rates include the provision of administrative functions necessary for services and are not billable beyond units provided to each authorized member.

Providers should reference the Rates and Service Codes chart of the contract for contract units and rates.

Providers should use increments as listed in the rates and service codes chart to issue payment to the SDS employee and bill LCI, up to the authorized number of units for the member. Providers can only bill for services rendered to the member. Provider will refund LCI the total amount of any/all units billed without services rendered to LCI member.

Family Care services administered by LCI are funded by state and federal tax dollars through the Medical Assistance program. As a publicly funded system, LCI strives to maintain the integrity of the program by ensuring that all services are billed as authorized by LCI, and as rendered to members. LCI ensures this protection by regularly conducting random reviews of claims submitted by its contracted providers. LCI reserves the right to request verification documentation from Providers. This could include but is not limited to' case notes, files, documentation, and records. LCI may require Providers to present evidence of sufficient financial reserves to operate home and meet member needs for at least 30 days without receiving payment for services rendered.

Section 3. HCBS Settings Rule

General Compliance All settings and locations must comply with Home and Community-Based Services (HCBS) rules and be determined compliant prior to eligibility for service provision under the Family Care waiver program.

Modifications to HCBS Requirements Modifications to HCBS settings rules are permitted to address health and safety risks. Such exceptions must be documented in the members' Person-Centered Plan (MCP) and the Provider's Individual Service Plan (ISP) and referred to as a Modification of Rights (MOR) Plan. All modifications must involve the members, Legal Decision Maker (LDM) if applicable, Interdisciplinary Team (IDT), and Provider.

Section 4. Standards of Service

Providers of services shall meet the standards of this agreement; and if applicable, agree to retain licensing in good standing during the contract period.

Providers of long-term care services are prohibited from influencing members' choice of long-term care program, Provider, or Managed Care Organization (MCO) through communications that are misleading, threatening, or coercive. Lakeland Care Inc and/or the Wisconsin Department of Health Services (DHS) may impose sanctions against a Provider that does so. Per DHS, any incidents of Providers influencing member choice in a Family Care program must be reported to DHS immediately.

Service must be provided in a manner which honors members' rights such as consideration for member preferences (scheduling, choice of Provider, direction of work), and consideration for common courtesies such as timeliness and reliability.

Provider must incorporate practices that honor members' beliefs, being sensitive to cultural diversity and diverse cultural and ethnic backgrounds, including supporting members with limited English proficiency or disabilities, and regardless of gender, sexual orientation, or gender identity. This includes fostering attitudes and interpersonal communication styles in staff and Providers which respect members' cultural backgrounds.

Section 5. Staff Qualifications, Training, and Competency

Providers shall ensure the competency of individual employees performing services to LCI members. Competency shall include maintaining any required certifications or licenses as well as assurance of the general skills and abilities necessary to perform assigned tasks.

Training of staff providing services shall occur within the first six (6) months unless needed before to safely provide services and include:

1) Provider Agency Policies and Procedures, including:
    a) LCI member and Provider rights and responsibilities
    b) Record keeping and reporting requirements to include incident reporting
    c) Other necessary and appropriate information
2) Understanding Individuals Served, including:
    a) Individual-specific disabilities, abilities, needs, functional deficits, strengths, and preferences
    b) Practices that honor diverse cultural and ethnic differences
    c) Person-specific and general training on the target population
3) Health and Safety Protocols, including:
    a) Recognizing and responding to conditions that may impact a member's health and safety
    b) Recognizing abuse and neglect and reporting requirements
    c) Emergency response and member-related incident procedures
4) Professional Skills and Conduct, including:
    a) Interpersonal and communication skills for effectively working with members
    b) Customer service training
    c) Confidentiality laws and procedures
    d) Handling complaints appropriately

If applicable to service provision, training on restraint seclusion and unplanned use of restrictive measures and reporting.

Provider shall ensure staff providing care will complete all required Training and Documentation Standards for Supportive Home Care set forth by the Department of

Health Services, October 2016 found here:
https://www.dhs.wisconsin.gov/publications/p01602.pdf

Provider shall validate the completion of this training within 10 days of the member's enrollment. These training requirements include the following:

1) **Personal Assistance Services: Worker Training Standards**
   Workers who provide personal assistance services or personal assistance and household services must receive training on the following subjects (unless exempted or waived per Exemption From or Waiver of Training section below):
   a. ***Policies, procedures, and expectations*** for workers, including HIPAA (Health Insurance Portability and Accountability Act) compliance and other confidentiality requirements; ethical standards, including respecting personal property and member right to refuse care; continuity of operations plan; management of testing service provider for disease; fraud and abuse and how to report; restrictive measures; refrain from influencing member to either enroll, or not enroll in, or to disenroll from Medicaid programs; safely providing services to members; and procedures to follow when unable to keep an appointment, including communicating an absence and initiating backup services.
   b. ***Billing and payment processes and relevant contact information***, including recordkeeping and reporting; contact information, including the name and telephone number of the member using the SDS option or representative, and the fiscal employer agent or co-employment agency.
   c. ***Recognition of, and response to, an emergency***, including protocols for contacting local emergency response systems; prompt notification of the member's fiscal employer agent or co-employment agency; notification of the contacts provided by the member and MCO IDT.
   d. ***Member-specific information***, including individual needs, functional capabilities, relevant medical conditions, strengths, abilities, member preferences in provision of assistance, SHC-related outcomes, advance directives of member, and the MCO care manager contact information (the member may provide this training component in whole, or in part).
   e. ***General target population***. Information that is applicable to the members the worker will serve.
   f. ***Providing quality homemaking and household services***, including understanding good nutrition, special diets, and meal planning and/or preparation; understanding and maintaining a clean, safe, and healthy home environment; respecting member preferences in housekeeping.
   g. ***Working effectively with members***, including appropriate interpersonal skills; understanding and respecting member direction, individuality, independence, and rights; procedures for handling conflict and complaints; cultural differences and family relationships. This component should include training on behavioral support needs, if applicable.

h. ***Electronic Visit Verification (EVV)***, if applicable per current EVV guidance, including how to access the system for steps for reporting. Investing time to train workers will provide a solid foundation for EVV.

2) Household/Chore Services: Worker Training Standards

Workers who perform only household chores shall receive the following training:

a. ***Policies, procedures, and expectations*** for workers, including HIPAA compliance and other confidentiality requirements; ethical standards, including respecting personal property and member right to refuse care; continuity of operations plan; management of testing service provider for disease; fraud and abuse and how to report; restrictive measures; refrain from influencing member to either enroll, or not enroll in, or to disenroll from Medicaid programs; safely providing services to members; and procedures to follow when unable to keep an appointment, including communicating an absence and initiating backup services.

b. ***Billing and payment processes and relevant contact information***, including recordkeeping and reporting; contact information, including the name and telephone number of the member using the SDS option or representative, and the fiscal employer agent or co-employment agency. .

c. ***Recognition of, and response to, an emergency***, including protocols for contacting local emergency response systems; prompt notification of the member's fiscal employer agent or co-employment agency; notification of the contacts provided by the member and MCO IDT.

d. ***Providing quality homemaking and household services***, including understanding good nutrition, special diets, and meal planning and/or preparation; understanding and maintaining a clean, safe, and healthy home environment; respecting member preferences in housekeeping. .

e. ***Member-specific information*** including individual needs, functional capabilities, relevant medical conditions, strengths, abilities, member preferences in provision of assistance, SHC-related outcomes, advance directives of member, and the MCO care manager contact information (the member may provide this training component in whole, or in part).

Exemption from or Waiver of Training

1) ***Exemption -*** Due to their own licensure or credentialing requirements, the following professions may be exempted by the responsible entity or entities from these training requirements: certified nursing assistant, licensed practical nurse, registered nurse, licensed physical or occupational therapist, or certified physical or occupational therapy assistant. When an exemption is granted, the member and FMS Provider jointly must still ensure that a worker performing medically oriented tasks, such as tube feedings, wound care, or tracheotomy care is competent in performing these tasks with the specific member.
2) ***Waiver -*** Some or all of the required training may be waived based on knowledge and skills attained through prior experience (e.g., as a personal care worker for a Medicaid-certified personal care agency). When a waiver is granted, the member and FMS Provider jointly must still ensure that a worker performing medically

oriented tasks, such as tube feedings, wound care, or tracheotomy care is competent in performing these tasks with the specific member.

3) ***Documentation*** - For workers exempted from some or all of the training requirements under subsections 1 or 2 of this section, the FMS Provider shall maintain copies of credentials or other documentation of their existence, or a written rationale for waivers based on experience, signed and dated by that entity.

Note: Notwithstanding any exemption or waiver under subsections 1 or 2 of this section, such workers will likely need agency and member contact information, information on billing, payment, documentation, and any other relevant administrative requirements, protocols for emergencies and member-specific information.

Completion and Documentation of Training

1) Timeframes
    a. Personal assistance services training shall be completed prior to providing personal assistance services.
    b. Household/chore services training shall be completed within two months of beginning employment.
2) Responsibility for Creating and Maintaining Documentation
    a. For SDS members who are common-law employers:
        i. Members who make training decisions shall document the training and any exemptions or waivers and maintain the documentation with the assistance of the fiscal/employer agent if within the scope of its work or.
        ii. If members do not make training decisions, the fiscal/employer agent if within the scope of its work shall document the training and any exemptions or waivers and maintain the documentation.

For SDS members who are co-employers, the co-employment agency shall document the training and any exemptions or waivers and maintain the documentation.

3) Content of Documentation
    a. Documentation shall list the training content, dates such training occurred, and for exemptions and waivers, the credentials and/or rationale that are the basis for any training exemption or waiver.
    b. Documentation that training requirements have been met through provision of training and/or exemption or waiver shall be signed and dated by the entity or entities making those decisions.
    c. Additional Training: The entity responsible for making and documenting training decisions shall ensure the worker completes appropriate additional training if the worker's job duties change and require additional knowledge and/or skills

The FMS Provider's tasks related to managing SDS finances could include but are not limited to:

1) Providing education to the member and potential employees regarding employment-related paperwork to ensure the timely implementation of SDS.
2) Completing and explaining necessary eligibility, tax and insurance paperwork with the member and potential employees.
3) Performing comprehensive background checks and providing LCI with findings in a timely manner.
    a. A comprehensive background check will include:
        i. Background Information Disclosure Form (BID)
        ii. Department of Justice (DOJ) Report
        iii. Department of Health Services (DHS) (Adults) or Department of Children & Family Services (DCF) (Children) Report
        iv. Office of Inspector General (OIG) Report
        v. Caregiver Misconduct Registry report
4) Supply the member with access to timesheets and instructions on completing and submitting them, including clearly communicating the pay period schedule and schedule for timesheet deadlines
5) Promptly issuing employee paychecks based on approved timesheets.
6) Withholding and depositing income tax, within the state of WI Department of Workforce Development (DWD) standards.
7) Managing FICA, FUTA and SUTA in accordance with federal and state requirements.
8) Providing necessary year end taxation form to members and employees.
9) Secure workers compensation insurance and manage any claims or issues arising from SDS employees' work-related injuries or illnesses
10) Timely Communication of concerns with the IDT staff regarding identified or suspected fraudulent activity related to budget utilization
11) Addressing and resolving member and/or worker concerns related to payment for services rendered in collaboration with the LCI IDT staff.
12) Providing clear, easy-to-access (or regularly mailed) summaries to both the member and IDT staff.

Section 6. Staffing Assignment and Turnover

The provision of successful services is attributable in large part to the strength of the relationship between a member and the staff directly providing the service. Given this, the Provider agrees to make every effort to match and retain direct care staff under this agreement in a manner that optimizes consistency.

Changes in staff assignments to specific members and within the organization are at the discretion of the Provider. The Provider agrees to take member requests for specific staff into consideration when assigning or reassigning staff to specific members and will notify LCI SDS Specialists of any changes to staff providing services

To establish and preserve this relationship, Providers must have a process in place for:

1) Members to provide feedback on their experience with the employees performing these tasks and respond when appropriate.

2) Written information indicating who within the organization to contact with concerns, or questions related to the provision of services or direct care staff.
3) Forwarding documentation and/or feedback to the IDT staff to allow members to express concerns to individuals other than the individual who performs the task.
4) Ensuring staff are supervised and assessed for effective collaboration with those they serve by conducting onsite supervision and review.
5) Ensuring performance issues are addressed promptly and LCI IDT staff are kept informed about significant issues when members are impacted.
6) Collaboration and communication between members, IDT staff, and all other stakeholders.

Section 7. Communication, Collaboration, and Coordination of care

LCI regularly utilizes the following platforms to communicate with Providers:

1) Provider Network Advisory Committee
2) Provider Newsletter
3) LCI Website
4) Email Notifications
5) Provider Portal

Provider agencies are required to ensure LCI Provider Relations staff, LCI IDT staff, Legal Representatives, and other identified individuals identified within the members' team have accurate and current Provider contact information to include address, phone numbers, fax numbers, and email addresses.

Providers will notify MCO of formal complaints or grievances received from MCO members within 48 hours of receipt. Written notification of completed complaint investigations will be forwarded to the LCI interdisciplinary team.

All aspects of services shall be discussed between the LCI IDT staff, member or legal representative, and Provider to ensure proper collaboration. Provider will ensure effective collaboration and communication with LCI staff.

The Provider agency shall report to the LCI IDT staff whenever:

1) There is a change in service provider
2) There is a change in the member's needs or abilities
3) The member or Provider is not available for scheduled services (within 24 hours unless an alternate date is scheduled between Provider and member)

The Provider agency shall give at least 30 days' advance notice to the LCI team when it is unable to provide authorized services to an individual member. The Provider agency shall be responsible for providing authorized services during this time period. The LCI team or designated staff will notify the Provider agency when services are to be discontinued. The LCI team will make every effort to notify the Provider at least 30 days in advance.

Member Incidents

Provider agencies shall report all member incidents to the LCI IDT. Providers must promptly communicate with the LCI IDT regarding any incidents, situations or conditions that have endangered or, if not addressed, may endanger the health and safety of the member. Acceptable means of communicating member incidents to the LCI team would be via phone, fax, or email within one (1) business day. The Provider must include a description of the incident, factors leading up to the incident, and the actions and steps immediately taken by the Provider to prevent further harm to or by the affected member(s).

Providers shall record and report:

1) Changes in:
    a) Condition (medical, behavioral, mental)
    b) Medications, treatments, or MD order

2) Incidents or suspected incidents of:
    a) Abuse, Neglect, or exploitation
    b) Medication Errors
    c) Falls (with or without injury)
    d) Urgent Care or Emergency Room visits or Hospitalization
    e) Death: anticipated or unexpected
    f) Elopement or Missing Person
    g) Emergency or Unapproved use of restraints or restrictive measure
    h) Fire or other Natural Disaster affecting the home
    i) Any other circumstances warranting an agency incident or event report including news or social media story involving the member, facility, or staff.

***Note**: Provider staff will first follow their own established in-house protocols for reporting incidents. Staff will then inform the IDT of any member circumstance that would warrant family or physician notification that includes but is not limited to the above circumstances*.

All reported incidents will be entered into the LCI Adult Incident Reporting System (AIRS) and reported to DHS in accordance with MCO contract requirements. Providers may be asked to provide any additional information or details necessary to complete the investigation of reported incidents. The Provider will inform LCI when notifying their regulatory authority of incidents. A copy of the report may be submitted as a form of notification.

Section 8. Documentation

Providers shall comply with documentation as required by this agreement and state licensure and certification requirements as expressed by ordinance, state and federal rules and regulations applicable to the services covered by this contract.

The Provider is responsible for paying the members' SDS employees on a timely basis and keeping an account of disbursements while assuring that sufficient funds remain available. The documentation demonstrating the financial activities of the member's

SDS services must be made available via regular, routine reporting and upon request by LCI.

1) The Provider will provide monthly spending summaries via mail and/or email to members containing the following elements:
    a. Services on the member's SDS plan.
    b. Service utilization for the period (monthly or to date), amount of SDS plan already used, processing to be paid, and remaining percentage/total monthly.
2) The Provider will monitor members' unusual spending and utilization patterns. The Provider will immediately contact LCI IDT staff via written communication (email) or telephone to inform them of any extraordinary spending (spending that may disrupt the authorized budget).

The Provider must retain all documents and records for seven years as required by law and regulations. Records shall be organized so that non-accountants can easily understand individual members' accounting records.

At any time, the IDT staff may request a written report to enhance the coordination and/or quality of care, which includes:

1) Changes in members' activities
2) List of supportive tasks provided
3) Ongoing concerns specific to the member
4) Additional documentation of the services provided

The Provider agency must maintain the following documentation and make available for review by LCI upon request:

1) Provider meets the required standards for applicable staff qualification, training, and programming
2) Verification of criminal, caregiver and licensing background checks as required.
3) Policy and procedure for responding to complaints, inappropriate practices or matters qualifying as member-related incidents.
4) Employee timesheets/visit records which support billing to LCI.
5) For live-in SDS workers, verification of the workers' permanent residence must be maintained annually based on the Forward Health definition of a live-in worker. The Provider is required to retain all documentation supporting live-in worker status.

Section 9. Additional Considerations

- Services will be provided as identified and authorized by LCI IDT staff.
- Provider is required to comply with all applicable Wisconsin state law regarding Caregiver Background Checks and Wisconsin Administrative Rule DHS 12 as they pertain to services provided to LCI members.
- Provider will collect and submit to LCI the required SDS worker information for the subsequent assignment of the SDS worker's Medicaid ID. Provide will submit any updates on the SDS worker's information to LCI to ensure continued compliance with federal regulations

- LCI pre-authorizes all its services. If Provider bills for more units than authorized without prior authorization, these services may be denied.
- In the case that an LCI member cancels service, the Provider must contact the LCI IDT staff. Services cancelled will not necessarily be rescheduled and should not be assumed by the Provider.
- The Provider will negotiate contract rates that include mileage and travel time associated with the provision of service.
- The Provider's staff shall have access to appropriate communication device(s) when out of the office during business hours (email, cell phone, etc.).

Provider Tax ID: _____

Authorized Provider Name: _____

Authorized Provider Signature: _____

Date: _____