PARENTS AS PAID CAREGIVERS ACKNOWLEDGEMENT OF UNDERSTANDING

MEMBER NAME	*AHCCCS ID #*

INSTRUCTIONS:

1. The form shall be completed after a decision (or review of the decision) has been made regarding the election of the Parents as Paid Caregivers (PPCG) service model as a result of the use of the "Minor Caregiver Options: Discussion Guide and Decision Roadmap" tool (refer to AMPM Exhibit 1620-21) and at a minimum reviewed/signed. Therefore, this form shall be reviewed and completed no less than on an annual basis.

2. This form should not be completed until a provider agency(ies) has been identified that will be authorized to provide the member's care and the parent has agreed to be employed or contracted by the agency(ies).

3. There must be one of these forms completed for each parent, when multiple parents are supporting the same child.

4. Parents must acknowledge each statement by signing their initials next to the statement. It is permissible for a parent to indicate "Not applicable or N/A" for those statements that are specific to the EPD/DDD program and don't apply because their child is not a member of that program.

5. Parents should seek clarification from the provider agency(ies) or the ALTCS Case Manager, as appropriate, prior to initialing statements and signing the bottom of the form.

6. The form shall be signed by the parent and ALTCS Case Manager.

7. A copy of the completed form shall be retained as an exhibit to the member's Person-Centered Service Plan (PCSP).

8. A copy provided to the parent and distributed to the provider agency(ies) the parent is or will be employed or contracted with to provide paid care.

STATEMENT	INITIALS
1. I understand the total number of service hours that my child is assessed for are medically necessary and extraordinary care, which is determined by the service planning process, and is separate and apart from the decision about the service provider agency authorized to provide the service or individuals providing the service(s).	
2. I voluntarily agree to provide paid care that aligns with my child's PCSP.	
3. I agree to support a personal goal(s) in the PCSP focused on my child engaging with other children in the community.	
4. I understand that I will either be employed or contracted by the service provider agency and must comply with any standard employee/contractor requirements including service provider agency specific requirements.	
5. I understand that before I can provide paid care, I must meet all qualifications including:	
a. Be at least 18 years old or meet the age requirement determined by the service provider agency,	
b. Have or be able to obtain the following documentation:	
i. Evidence of being trained in Article 9 if my child is a DDD member,	
ii. Evidence of being trained in CPR/First Aid, and	
iii. Evidence of completing Direct Care Worker (DCW) Training, as directed by the service provider agency.	
c. Have evidence of being trained in the delivery of habilitation services as directed by the service provider agency.	
d. Pass background checks including checks of the Department of Child Safety (DCS) Central Registry and the Adult Protective Services (APS) Registry.	

STATEMENT	INITIALS
6. If my child is a member of DDD, I understand the following regarding Level 1 fingerprint clearance per ARS 36-594.01:	
a. If I am only providing attendant care and I reside in the same home as my child, I DO NOT have to obtain a Level 1 fingerprint clearance card,	
b. If I am only providing attendant care and I DO NOT reside in the same home as my child I DO have to obtain a Level 1 fingerprint clearance card, and/or	
c. If I am providing habilitation, I DO have to obtain a Level 1 fingerprint clearance card.	
7. If my child is an ALTCS EPD or Tribal ALTCS member, I understand that per the AMPM Policy 1240-A and AMPM Policy 1240-E, I am required to pass a criminal background check.	
8. I understand I have to comply with continuing education requirements as directed by the service provider agency.	
9. I understand that I cannot work and be paid by another employer during the hours I am getting paid to provide services to my child.	
10. I understand that I cannot have personal or familial responsibilities that conflict with my child's needs being met while I am getting paid ("on the clock") to provide care (i.e., running errands, volunteering, caring for other children or family members) as outlined in the PCSP.	
11. If my child is an ALTCS member of DES/DDD, I understand the requirements of Article R6-6-901-910 must be met during all the times I am being paid for care by a service provider agency. Corporal punishment ("spanking"), "time-outs", withholding access to basic needs such as food (e.g., "no dinner until after your room is clean") are examples of techniques parents may use but are not techniques a parent who is a paid to provide care may use.	
12. I agree to contact the service provider agency if I am no longer able to provide paid care on a permanent or temporary basis and an alternative caregiver is needed. This includes situations where I might need to reduce the number of hours I am getting paid to provide care. I must also share this information with my child's ALTCS Case Manager during their next visit.	

STATEMENT	INITIALS
13. I understand the service provider agency will develop a contingency plan with me to ensure my child receives care should there be an unforeseen circumstance that arises, and I am unable to provide the services. If there is an unplanned circumstance that prohibits me from being able to provide the paid care on a particular day, I will contact the service provider agency as soon as I am aware of this situation to implement the contingency plan.	
14. I understand that if my child is assessed as needing more than 40 hours of paid care (i.e., attendant care and habilitation) in a week, a non-parent caregiver must be identified to provide any care for over 40 hours in a week.	
15. I agree to partner with the service provider agency to support the recruitment of competent caregivers to serve my child to meet their needs and preferences including alternate caregivers for when I am unable to provide the paid care and/or caregivers to provide respite services.	
16. I understand that I am limited in the paid care I can provide as follows and these limitations will be monitored by both my service provider agency and my child's health plan:	
a. I shall not provide more than 40 hours of paid care in a seven-day period	
b. If another parent and I are providing paid care to our child, the combined hours between both parents cannot exceed 40 hours of paid care in a given week to that child regardless of the hours are split between multiple service provider agencies, and	
c. I may not provide more than 16 hours of paid care in a 24-hour period to any combination of DDD members and any combination of services (e.g. one member participating in PPCG, 2+ children participating in PPCG, other non-PPCG participating members).	
d. I shall be employed/contracted by one agency. If another parent and I are providing paid care to our child, both of us shall be employed/contracted by the same agency.	
e. I shall not receive pay for services when my child is not present	
f. I shall not receive pay for services when my child is receiving care by a licensed provider or at a licensed outpatient or inpatient facility	
g. I shall not receive pay for services for cleaning, laundry or meal preparation tasks	

h. I shall not receive pay for services between the hours of 10:00 pm and 6:00 am unless my child has a unique need that has been documented in the HCBS Needs Tool.	
17. I agree to comply with Electronic Visit Verification (EVV) requirements and any other documentation requirements as directed by the service provider agency (i.e., progress notes for habilitation services). If I have questions about EVV I will ask my service provider agency.	
18. I agree to comply with supervisory visits from my service provider agency.	

STATEMENT	INITIALS
19. I agree to comply with 90-day visitation in my home by my child's ALTCS case manager.	
20. I agree to follow my service provider agency's policies on reporting critical incidents (e.g., abuse, neglect exploitation, injury).	
21. I understand that any earned income as a paid caregiver and may have an impact on AHCCCS eligibility (or other publicly funded benefits) for the rest of the household, including "difficulty of care" payments that may be excluded wages when certain criteria are met.	
22. I understand the extra income could have an impact on other publicly funded benefits either myself or my family are receiving (e.g., SNAP, housing).	
23. I agree to share with the service provider agency or ALTCS Case Manager if myself or our family unit could benefit from some resources to support our ability and availability to provide paid care (e.g. resources to help focus on our own health and wellbeing or training needs).	

By signing this form, I am attesting to my understanding that if I am found not in compliance with any of these statements I have acknowledged, I may lose my ability to participate in the parents as paid caregiver program.

SIGNATURE OF PARENT: *DATE:*

PRINTED PARENT NAME

SIGNATURE OF ALTCS CASE MANAGER: *DATE:*