THE CDPAP PROGRAM INFORMATION GUIDE

&

PERSONAL ASSISTANT HANDBOOK

Health Aide Inc.
Fiscal Intermediary
Consumer Directed Personal Assistance Program

WHAT IS THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP)?

The Consumer Directed Personal Assistance Program (CDPAP) is an alternative to traditional home care. The Consumer Directed Personal Assistance program is a Medicaid program that enables self-directing individuals or their Designated Representative, to assume the responsibilities of their own care. The Consumer and/or their Designated Representative is responsible for recruiting, interviewing, hiring, training, supervising, scheduling and termination.

THE ROLE OF THE PERSONAL ASSISTANT (PA)

As a PA your job is to assist the Consumer with their individual needs to live safely in their home within the approved hours authorized by NYS Medicaid/Managed Care. By accepting this position, you are agreeing to accept training and supervision at the direction of the Consumer or their Designated Representative. You are responsible to complete the full application and submit the documents needed to work as a Personal Assistant.

> *You may not begin working for any reason for a Consumer until your application forms are completed and you have completed the hiring process. Your Consumer will be notified by HEALTH AIDE INC. when the approval for you to begin working can commence.*

As a PA, the Department of Health requires that you pass and submit a physical within the past year, provide proof of immunizations, a PPD or Chest x-ray (if you have a history of a positive PPD), and complete a health assessment. All forms are in the PA application. It is your responsibility to keep your compliance up to date yearly.

THE ROLE OF THE HEALTH AIDE INC. CDPAP PROGRAM

HEALTH AIDE INC. is the Fiscal Intermediary. As the Fiscal Intermediary, HEALTH AIDE INC. will keep a record which consists of the PA's original application forms, annual health assessments and the information needed for payroll processing and benefit administration. HEALTH AIDE INC. only acts as the "employer of record" for processing the payroll, and administering any insurance, unemployment and worker compensation benefits for the PA.

WORKING SAFELY IN THE CONSUMERS HOME

In the case of accidents that result in injury, regardless of how insignificant the injury may appear, PA's should immediately notify your Consumer or Designated Representative and HEALTH AIDE INC.

CORPORATE COMPLIANCE: FEDERAL & STATE FALSE CLAIMS POLICY

HEALTH AIDE INC. is to be in compliance with all Federal and State rules, laws and regulations to prevent, detect and correct any fraud, abuse or waste in connection with Federal and State funded health care programs and private health plans.

This includes compliance with all reimbursement rules as required by Medicare, Medicaid, and relevant third-party payers. It also includes compliance with relevant Federal and State abuse laws, including but not limited to the Deficit Reduction Act of 2005 and the Federal and NYS False Claims Act. Compliance issues relating to accurate and truthful documentation, honest and lawful dealing with others and prohibitions against receiving or giving remuneration in turn for referrals are also included. As part of this compliance program, all PA's are urged to raise any concerns about the accuracy or propriety of any documentation or billing practice or any other compliance issue without concern for retaliation. Such issues may be raised to HEALTH AIDE INC. Compliance Officer. All concerns will be reviewed and appropriate action will be taken.

PREVENTING MEDICAID FRAUD & ABUSE: THE DEFICIT REDUCTION ACT OF 2005

It is the objective of HEALTH AIDE INC. to provide information to all Personal Assistants, contractors and agents about the Federal and State False Claims Acts remedies available under these acts and how Personal Assistants and others can use them. Information is also provided about whistleblower protections available to anyone who claims or witnesses a violation of Federal or State false claims acts. We also will advise our Personal Assistants, contractors and agents of the steps the HEALTH AIDE INC. has in place to detect health care fraud and abuse.

This act is designed to improve, federal and state oversight and enforcement actions against fraud and abuse in the Medicaid program. It requires any entity receiving Medicaid funds to instruct their workforce on the following issues:

- The Federal Program Fraud Civil Remedies Act.
- The Federal False Claims Act.
- Whistleblower protections under such laws.
- State laws pertaining to civil or criminal penalties for false claims and statements.
- The role of such laws in preventing and detecting fraud, waste and abuse.
- Policies and Procedures of HEALTH AIDE INC. for preventing and detecting fraud, waste and abuse.

THE FEDERAL FALSE CLAIMS ACT

The False Claims Act is a law that prohibits a person or entity from knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government. It prohibits a person from 'knowingly" making, using, or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal health care programs, such as Medicare and Medicaid. A person or entity found guilty of violation can be obligated to civil penalty up to $11,000.00 plus three times the amount of actual damages. A person or entity can also find themselves excluded from the Medicaid programs if found in violation.

NEW YORK FALSE CLAIMS ACT

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care plans such as Medicaid. The penalty for filing a false claim is $6,000.00 to $12,000.00 per claim and the recoverable damages are between two and three times the value of the amount falsely received.

Health Aide Inc. will ensure that no claims for services excluded relatives are submitted by using several procedures to validify claims. This includes:

1) Validating all time sheets via PA checking in and out of work via phone calls
2) Random visits to the consumers' homes during scheduled hours of PA service
3) Calls to consumers' homes during set hours of services to ensure that the correct PA is delivering the service.

PAYROLL INFORMATION

Federal and State laws require HEALTH AIDE INC. to keep accurate records of time worked in order to calculate PA pay and benefits. Time worked is all the time actually spent on the job performing assigned duties within the authorized time. You are not permitted to work anywhere else at the same time you are working for your Consumer.

Personal Assistants are paid on a **Weekly** basis.

Timesheets to be submitted by: **Monday @5:00 PM**

The week starts on: **Sunday**

PAs must use the Electronic Attendance Verification System to call in when they arrive and to call out when they leave. On those occasions when calling from the Consumer's home is not possible, permission may be granted to use paper time sheets. Please be advised that all time sheets must be signed by the Consumer/Designated Representative and PA at the end of each day. Dates, times, signatures and Consumer information must be filled out correctly. We will not be able to process incomplete paperwork.

USE OF THE ELECTRONIC ATTENDANCE VERIFICATION SYSTEM (EAVS)

HEALTH AIDE INC. requires the use of an EAVS when working with their Consumer. You are required to use the EAVS system when you report to work for the Consumer, and when you have completed your shift. At orientation you will be provided with an ID number and instruction on how to use the EAVS. It is prohibited to allow anyone else to use your ID number. PA's must call in and out for each shift that is worked. Failure to use the call-in system properly will cause a delay in your pay due to the additional processing time needed for timesheets.

Payroll checks will be mailed weekly to the Consumer's home or you can choose to receive your pay via direct deposit. HEALTH AIDE INC. highly recommends you choose the direct deposit benefit to avoid disruptions in check distribution due to weather or failed delivery methods.

COMPENSATION RATE

Your rate of pay is _____ per hour. (Must be between $15.00-$18.60 per hour)

Overtime is paid at regular rate time & ½.

LIVE-IN PERSONAL ASSISTANT

Pursuant to 18 NYCRR § 505.28(b)(12), *Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer´s medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep. [18 NYCRR § 505.28(b)(12)]

Personal Assistant Name: _____

Personal Assistant Signature: _____

Health Aide Inc. -Fiscal Intermediary Representative Name: Fred Polsky

Health Aide Inc. -Fiscal Intermediary Representative Signature: _____

PERSONAL ASSISTANT APPLICATION CHECKLIST

Name of Personal Assistant: _____

Date: _____

Consumer's Name:

Consumer's Address:

Consumer's Phone Number:

- Application Form
- W-4 Form
- Signed Consumer/PA wage agreement
- Consumer Offer of Employment letter LJ Signature
- Verification Form
- DOL Acknowledgement of wage rate/payday
- PA disclosure statement signed
- Consumer Employment Letter signed
- False Claims Acknowledgement
- 1-9 Form
- Driver's license / US Passport or other:
- Social Security Ca[r]d (original ID only)
- Health Assessment
- PPD Mantoux date:
- Chest x-ray (if needed)
- *Physical (within* the past year)
- Rubella Titre
- Rubeola Titre
- Or MMR lst date: _____2nd date: _____
- Photo ID
- Direct Deposit Form completed

OFFICE USE ONLY

PA Application completed on:

PA Notified on:

Consumer Notified on:

Additional Comments:

PERSONAL ASSISTANT APPLICATION

You must complete all the enclosed forms before you will be authorized and permitted to start work. Please note that approval to start work will come from HEALTH AIDE INC.

1. All PA enrollment forms enclosed must be completed and returned before employment can be authorized.

2. When completing the forms be sure that the Consumer signs the forms where their signature is required.

3. When you have completed all the forms you or the Consumer must contact HEALTH AIDE INC. enrollment department and make an appointment to complete the PA enrollment process.

4. You must bring with you the following original documents when you come to the office for your appointment:

- US Birth certificate or Passport, or Unexpired Foreign Passport, or an Alien Registration Card,
- Valid Picture (Photo) ID,
- Original signed Social Security Card (no copies),
- Current Physical Exam, including a PPD for TB and a copy of the lab tests for Rubella. If you were born after 1957 you will also need a Rubeola (Measles) lab test; or proof of vaccination from your Doctor that has the lab values.

Health Aide Inc. Application for Employment

_____

First Name Middle Name Last Name Maiden Name

_____ _____

Social Security Number Date of Birth

_____

Home Address Apt# City State Zip

Length of time at address: _____

_____

Home Phone Number Cell Phone Number Other Contact Number

US Citizen: ❑ Yes ❑ No If no, USCIS ID Number: _____

Seeking: ❑ Full Time ❑ Part Time ❑ Evenings ❑ Weekends ❑ Per Diem
Minimum Salary Requirement: _____ per ❑ Hour ❑ Week ❑ Annum
I am licensed/certified in New York State, with a current and valid license/certification as a:
❑ RN ❑LPN ❑HHA ❑ CNA ❑ PCA ❑ PT ❑ APT ❑OT

School Attended	Name of school and address	Did you graduate?	Date of Completion	Diploma/Degree/ Certification
High School		□ YES □ NO	/ /	
College		□ YES □ NO	/ /	
Graduate School		□ YES □ NO	/ /	
Business School		□ YES □ NO	/ /	
Aide Training		□ YES □ NO	/ /	
Other		□ YES □ NO	/ /	

Professional/Para-professional Licenses and Certifications

Profession: Yes❑ No❑	License #:	Expiration date:	Verified:
Profession: Yes❑ No❑	License #:	Expiration date:	Verified:
HHA ❑ PCA❑ Yes ❑ No❑	School/Training Program:		Verified:
HHA ❑ PCA❑ Yes ❑ No❑	School/Training Program:		Verified:

Other:

WORK HISTORY (Minimum of two (2) years)

1. Company Name _____
Address _____
Name of Supervisor: _____ Phone #: _____
Fax #: _____ Email: _____
Position Held: _____ Duration of Employment: From _____ to _____
Reason for leaving: _____

1. Company Name _____
Address _____
Name of Supervisor: _____ Phone #: _____
Fax #: _____ Email: _____
Position Held: _____ Duration of Employment: From _____ to _____
Reason for leaving: _____

Have you ever been convicted of a crime? ❑ YES ❑ NO
If yes, please explain: _____

Do you have a valid NYS Driver's License? ❑ YES ❑ NO Do you own a car? ❑ YES ❑ NO
Are you able to lift at least 50lbs? ❑ YES ❑ NO

Languages *fluently* spoken: _____

Statement:
All information I have provided in this application is true. If employed, I understand that false information on this completed application, is cause for termination. Upon employment, I will comply with all Health Aide Inc.'s rules and regulations regarding my employment. Health Aide Inc. will request information regarding my background which will include work and personal references and criminal background check. I hereby release them and Health Aide Inc. and its agents from all liability which my follow from the release of such information. Health Aide Inc. does not discriminate based on sex, age, physical handicap, race, sexual orientation, creed/religion, or national origin. This agency is an equal opportunity employer.

I understand that potential employment will be on an at-will basis, for no definite term. As such, I understand that I will enjoy the right to terminate my employment at any time, and that Health Aide Inc. will similarly possess the right to terminate my employment at any time.

_____ _____
Signature Date

_____
Print First and Last Name

EMPLOYEE AGREEMENT

To comply with the terms of the Concepts Consumer Directed Personal Assistance Program (CDPAP), as well as HEALTH AIDE INC. and Local Department of Social Services Program contract:

THE PERSONAL ASSISTANT AGREES TO:

1. Recognize the authority of the Consumer as the Personal Assistant's source of employment and supervisor.

2. Respect the Consumer s health, wellbeing, privacy and property.

3. Authorize HEALTH AIDE INC. to collect and appropriately distribute employment related information. Comply with the policies and practices of HEALTH AIDE INC.

4. Keep your Coordinator at HEALTH AIDE INC., or the Local Consumer Organization Program Coordinator (if applicable) informed of any changes in the statues including but not limited to the Consumer's address, telephone number, any incidents/accidents or hospitalization.

5. Process in a timely manner the required enrollment documents, annual worker health assessments, medical attestations: PPD/Drug test, and other required employment documents.

6. Understand that you are accountable for working the hours assigned for the consumer by his/her Social Services Program, which must also correspond with EAVS /timesheet (if requested)

7. Realize that you cannot accept any other type of employment simultaneously during the hours you are working with your Consumer.

Consumer Directed Personal Assistance Program (CDPAP)

- I understand that I cannot be working for any other employer simultaneously during the hours I work with my consumer.
- I have read the above and agree to comply.

_____
Personal Assistant Name

_____ _____
Personal Assistant Signature Date

Fred Polsky
_____
Health Aide Inc. -Fiscal Intermediary Representative Name

_____ _____
Health Aide Inc. -Fiscal Intermediary Representative Signature Date

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

► _____ **Employee's signature** (This form is not valid unless you sign it.) ► _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

health aide

NEW YORK STATE OF OPPORTUNITY.

Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name:

Health Aide Inc.

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

501 West 168th St. Suite 5
New York, NY 10032

Mailing Address:

670 Myrtle Avenue PMB #564

Brooklyn NY, 11205

Phone: 347-620-6226

2. Notice given:

- [x] At hiring
- [x] Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:

$_____per hour

4. Allowances taken:

- [x] None
- [ ] Tips_____per hour
- [ ] Meals_____per meal
- [ ] Lodging _____
- [ ] Other _____

5. Regular payday: Friday

6. Pay is:

- [x] Weekly
- [ ] Bi-weekly
- [ ] Other

7. Overtime Pay Rate:

$_____per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:

- [ ] I have been given this pay notice in English because it is my primary language.
- [ ] My primary language is_____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

LS 54 (01/17)

ACA BENEFIT WAIVER FORM

Employee Name: _____
Date_____

I am employed by _____ as a full-time employee (working at least 30 hours per week). I am being given the opportunity to enroll myself and my dependents in the Minimum Value/ACA Compliant group health benefits plan(s) offered by my employer at an Affordable Level and I decline this coverage.

Duration of Coverage in This Offer: **January 1st 2018 – December 31st 2018**

I decline this coverage, because I have coverage from:

- ☐ **My spouse's employer**
  Insurance Name: _____ Policy Number: _____
- ☐ **Medicare**
  Insurance Name: _____ Policy Number: _____
- ☐ **Medicaid**
  Insurance Name: _____ Policy Number: _____
- ☐ **Union health plan**
  Insurance Name: _____ Policy Number: _____
- ☐ **Another source of coverage (please specify): _____**
  Insurance Name: _____ Policy Number: _____

I certify that all information provided in this form is true and complete. By declining group health benefits, I acknowledge that I and/or my dependent(s) may have to wait until the plan's next open enrollment period to request group coverage and that I may not qualify for a subsidy on the PPACA Health Exchange. I also acknowledge that by declining coverage I could be subject to a penalty under the Individual Mandate.

Print Name_____

Date of Birth_____

Signature_____

Date_____

Your plan sponsor or certain third parties affiliated with the plan sponsor may provide you with information regarding health care coverage options available to you and your family through your employer or through certain alternative coverage options. All such information is provided for informational purposes only, and all decisions relating to your health care coverage must be made by you and your family exclusively, in consultation with your advisors. Any statement made by any individual relating to your coverage options is only a starting point for the work you need to do to confirm the information is applicable to your situation and to determine which coverage option is best for you and your family, given that much of the information is brief and important information may be omitted. Your employer provides no incentive, recommendation or advice relating to any alternative coverage or what option is appropriate for you.

ATTESTATION TO COMPLY WITH REGULATIONS

Consumer: _____

Name of Personal Assistant: _____

- I understand that it's against the New York State CDPAP regulations to work as a Personal Assistant in HEALTH AIDE INC. If
    1. I am the parent of a consumer younger than 21.
    2. I am the spouse of a consumer.
    3. I am the consumer's designated representative

- I am at least 18 years old.

- I agree to complete a pre-employment physical before I begin work, then annually.

I understand that I must not work for a Consumer who is in the Hospital or Nursing Home or other health related facility other than the Consumers home.

I have read all the above statements, and will comply with these requirements. I also understand that failure to abide by the rules stated above could be considered Medicaid Fraud and could subject me to investigation and possible criminal prosecution by the Office of the Attorney General Medicaid Fraud Control unit, and the Medicaid Inspector General.

Personal Assistant Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

I have received, read, and understand my role and responsibilities as Personal Assistant working for a Consumer or his/her Designated Representative participating in the HEALTH AIDE INC. CDPAP Program.
I have had an opportunity to ask questions concerning my wage and benefit package.

- I understand that as the Fiscal Intermediary, HEALTH AIDE INC., is responsible for processing on behalf of the Consumer the payroll and benefit administration for the PA.
- I understand that I am hired, trained, supervised and receive my schedule by the Consumer and/or their Designated Representative.
- I understand it is the Consumer or Designated Representative who can terminate my services or dismiss me from working for them if they choose to do so.

Personal Assistant Name: _____

Personal Assistant Signature: _____

Date: _____

HEALTH AIDE INC. -Fiscal Intermediary Representative Signature: _____

HEALTH AIDE INC. -Fiscal Intermediary Representative Name: Fred Polsky

Date: _____

ACKNOWLEDGMENT OF RECEIPT OF HANDBOOK

1. I acknowledge that I have received a copy of the Handbook.

2. I HAVE READ STATEMENTS PERTAINING TO FALSE CLAIMS AND FALSE STATEMENTS.

3. I have been informed regarding the policy for Federal and State False Claim Act and False

Personal Assistant Signature: _____

Personal Assistant Name: _____

Date: _____