Self Direct Option
Memorandum of Agreement

By signing this Memorandum of Agreement, I attest that I understand and agree to the following.

1. Employer will comply with all pertinent State and Federal laws and regulations, as well as standards and conditions that are applicable for the funding source program regulations, as they may be amended from time to time; including but not limited to applicable sections of the program regulations.
2. Employer has received instructions on how to obtain copies of program regulations and has been offered a copy by SeniorsPlus.
3. Employer has received and reviewed the Self Direct Option Training Manual.
4. Employer has received a Self Direct Option Training Packet, which includes resource information and forms to be used for required recordkeeping.
5. Employer has participated in a Self Direct Option Training.
6. Employer will work with the Care Coordinator who manages the plan of care.
7. Employer will keep a record on each employee that includes proof of compliance with staffing requirements.
8. Employer will maintain a client record, inclusive of all required forms.
9. Employer will provide SeniorsPlus with copies of any paperwork requested.
10. Employer will work with the Fiscal Intermediary with all that entails.
11. Employer will ensure all employees are screened, meet training requirements, and that appropriate background and registry checks are completed per program regulations.
12. Employer will allow SeniorsPlus to review my compliance and follow up to ensure all Self Direct Option requirements are met.
13. Employer will receive prior approval from the Care Coordinator before authorizing respite services or additional hours for the client.
14. Employer will maintain documentation of the monthly in-person contacts and other contacts, as required. This applies to the HCB and HBSS programs only.
15. Employer is responsible for any and all costs related to the day to day operations of their agency.

My signature below indicates that I understand that my failure to comply with any or all of the requirements, program regulations, this Memorandum of Agreement, or other pertinent State or Federal laws, are cause for one or more of the following: reimbursing SeniorsPlus for payments made on my behalf, and/or termination of the Self Direct Option. I understand that there are risks and liabilities involved in hiring and employing staff in this capacity. I accept the risks, responsibilities and liabilities that come with this Option.

Client Name: _____ Employer Name: _____

Employer Signature: _____ Date: _____

Skills Trainer Signature: _____ Date: _____

Please submit this completed form via email to: skillstrainer@seniorsplus.org

Client/Emergency Information

Employer: _____

Client Name: _____ Phone #: _____

Address: _____

Directions: _____

Date of Birth: _____ MaineCare/Medicaid#: _____ Medicare #: _____

Other Insurance: _____

Primary Physician: _____ Phone #: _____

☐ POA ☐ Guardian Name: _____

Address: _____ Phone #: _____

Emergency/contingency Plan: _____

Responsible Person: _____ Phone #: _____

Address: _____

Ambulance: _____ Town: _____ Phone #: _____

Next of Kin: _____ Phone #: _____

Diagnosis and Health Problems: _____

A copy of this Client/Emergency Information must be left in the client's home.

Employer Signature: _____ Date: _____

Revision Date: 3/22/2023

Plan of Care
Employee Assignment

Employer Name: _____

Client Name: _____

Address: _____

Telephone: _____ DOB: _____ M ☐ F ☐

Schedule: (designate in hours)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
__	__	__	__	__	__	__

Tasks (check all that are authorized on the referral)

☐ (9) Skin Care
☐ (28) Accompany to Care Plan Activity
☐ (32) Bathing
☐ (33) Dressing
☐ (34) Transfer
☐ (35) Eating/Feeding
☐ (36) Toileting
☐ (37) Bed Mobility
☐ (38) Locomotion
☐ (39) Meal Preparation
☐ (40) Daily Housekeeping
☐ (41) Laundry
☐ (42) Grocery Shopping
☐ (44) Routine Housework
☐ (63) Caregiver Respite
☐ (65) Health Maintenance- Ventilator
☐ (66) Health Maintenance-Tracheostomy
☐ (67) Health Maintenance-Suctioning
☐ (68) Health Maintenance-Cath/Ostomy
☐ (69) Health Maintenance-Feeding Tube
☐ (70) Health Maintenance Treatment/Dressing/Wounds
☐ (71) Health Maintenance-Care of Skin
☐ (72) Health Maintenance-Bowel Regime
☐ (73) Health Maintenance-General (Specific tasks defined on referral - define below):
_____, _____

Health Problems: _____

Special Instructions: _____

My signature below indicates that I have reviewed the Plan of Care with the client.

Employer Signature: _____ Date: _____

Revision Date: 3/22/2023

HBSS/HCB Contact and Visit Log

Representative: _____

Client: _____

Date of Visit or Contact	In Person Visit ✓	Other Contact (Phone, Email, Etc.) ✓	Notes
1/1/2016	✓		Client was in good spirits and is happy with services and employee.