

**State of Connecticut
Department of Developmental Services
Self-Directed Support Agreement**

Consumer Name: _____ **DDS #:** _____

Sponsoring Person: _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____ **Cell:** _____

DDS Region: _____ **Case Manager/Broker:** _____

As an individual receiving Self-Directed Supports and/or the sponsoring person for Self Directed Supports, I agree to abide by the following Department of Developmental Services requirements:

- To enroll in the DDS Home and Community Based Services Medicaid Waiver
- To maintain Medicaid eligibility while participating in the DDS Home and Community Based Services Medicaid Waiver.
- To meet all documentation requirements that the department requires for self directed services.
- All payments by the Fiscal Intermediary must be made directly to the provider of the service. Third party payments and advanced payments are not allowed.
- The Fiscal Intermediary will only make payments for services in the budget authorized by DDS. Original receipts are required from vendors for reimbursement for goods and services authorized in the individual budget.
- Any purchase of supports, services, or goods from a party that is related to me through family, marriage, business association or a consensual relationship must be prior approved by DDS.
- Budget adjustments are limited to a maximum of one time per quarter. (Jan-March, April -June, July - September, October - December) and are only for a change in the supports and services that are included in the Individual Plan.
- All employees I hire must meet the DDS pre-employment requirements prior to their hire date and complete the DDS required trainings within 90 days.
- The sponsoring person cannot be a paid employee.
- Funds allocated by the department are only for the services identified in the Individual Plan and cannot be used for any other supports or services unless included in the Individual Plan.

Revised 1.2009

Funds held by the Fiscal Intermediary that are not expended within the budget period are returned to the Department.

- Three bids are required for items, equipment, or home and vehicle modifications over \$2500.
- To enter into an agreement with a Fiscal Intermediary who is under contract with DDS.
- To actively participate in the ongoing monitoring of supports and services and to participate in the department's quality review process.
- Any special equipment, furnishings, or items purchased under this agreement are the property of the service recipient and will be transferred to his or her new place of residence or day program should the person move or be returned to the state when the item is no longer needed.
- To review and follow the DDS False Claims Act Policy provided by the Fiscal Intermediary.
- I acknowledge that the authorization and payment for services that are not rendered could subject me to Medicaid fraud charges under state and federal law. Breach of any of the above requirements with or without intent may disqualify me from self-directing-services.
- To notify my case manager if I am no longer able to meet the departments requirements for Self Direction.

You must be able to meet the responsibilities listed below. If you are not able to meet these responsibilities independently, you must have additional support identified in the Individual Plan for the areas where support is needed.

Self Directed Responsibilities	Need Assistance	Do not need Assistance
To participate in the development and implementation and review of the Individual Plan.	<input type="checkbox"/>	<input type="checkbox"/>
To hire, train and supervise my staff to meet the outcomes outlined in my individual Plan	<input type="checkbox"/>	<input type="checkbox"/>
To verify and approve time sheets, receipts, mileage logs, and invoices on the required forms and send to the Fiscal Intermediary.	<input type="checkbox"/>	<input type="checkbox"/>
To review the Fiscal Intermediary expenditure reports provided to me and notify my case manager and Fiscal Intermediary of any questionable expenditure.	<input type="checkbox"/>	<input type="checkbox"/>
To complete all forms provided by the Fiscal Intermediary that are required by federal and state laws to become the employer of record.	<input type="checkbox"/>	<input type="checkbox"/>

Self Directed Responsibilities	Need Assistance	Do not need Assistance
To ensure each candidate who is being considered for employment fills out a standard employment application provided by the Fiscal Intermediary.	<input type="checkbox"/>	<input type="checkbox"/>
To offer employment to any new employee on a conditional basis until the Criminal History Background Check, Drivers License Check, and DDS Abuse Neglect Registry Check has been completed.	<input type="checkbox"/>	<input type="checkbox"/>
To follow the department's procedure for candidates with a criminal history conviction record. Anyone on the DDS Abuse Neglect Registry cannot be employed to provide support to the individual.	<input type="checkbox"/>	<input type="checkbox"/>
To enter into an agreement with the individual support worker(s) I hire. The Individual Family Agreement with Employee provided by the Fiscal Intermediary identifies the type of supports the employee will provide and the hourly rate of pay.	<input type="checkbox"/>	<input type="checkbox"/>
To ensure that each employee I hire has read the required training materials and completed any specific training in the Individual Plan prior to working alone with the person	<input type="checkbox"/>	<input type="checkbox"/>
To ensure that employees I hire complete the department's College of Direct Supports internet based training requirements.	<input type="checkbox"/>	<input type="checkbox"/>
To ensure that each employee documents the start and end time for each date of service worked with the consumer and documents the activities and services provided for each date worked.	<input type="checkbox"/>	<input type="checkbox"/>
To ensure there is financial oversight and accountability of the individual's personal funds and entitlements by someone other than the employee.	<input type="checkbox"/>	<input type="checkbox"/>

Signed: Consumer _____ **Date:** ___/___/___

By signing above I agree to follow the self direction requirements and responsibilities in this agreement.

Signed: Sponsoring Person _____ **Date:** ___/___/___

By signing above I agree to follow the self direction requirements and responsibilities in this agreement.