Texas Department of Aging and Disability Services

Consumer Directed Services

New Employee Packet Cover Sheet

Form 1724
August 2005

Consumer Name:	Employer Name:
Employee Name:	Social Security No.
Date of Hire:	First Day of Work:

Employer	Agency	CDSA	Document Description / Form Information
AT TIME OF HIRE: (1) Original for Employer's Personnel Files AND (2) Copy to CDS Agency			
☐	**DADS**	☐	**Criminal History Check Applicant Authorization and Nurse Aide and Employee Misconduct Registry Verification** (DADS Form 1725)
☐	**DPS**	☐	**Texas Department of Public Safety (DPS) Criminal Conviction History Check for Applicant** (prior to employment/service delivery)
☐	**USCIS**	☐	**Form I-9 Employment Eligibility Verification**; Copy of Form I-9 only to CDSA. *Employer **must** verify that each document required and used to verify the employee's employment eligibility is renewed prior to its expiration date; do not send copies of documents to CDSA.*
☐	**OAG**	☐	**New Hire Reporting –** Office of the Attorney General (OAG), State of Texas (within 20 days of hire); recommended that reporting be made at time of hire. [The OAG transmits the report to the *National Directory of New Hires.*]
☐	**IRS**	☐	**IRS Form W-4 – Employee's Withholding Allowance Certificate** Due before first payroll check is calculated; provide to CDSA on date of hire.
☐	**DADS**	☐	**Applicant Verification:** age, relationship, CPR, driver's license and insurance, initial orientation, work schedule; DADS Form 1729
☐	**DADS**	☐	**Liability Acknowledgement**, DADS Form 1728
☐	**DADS**	☐	**Wage and Benefit Plan**, DADS Form 1730; any court-ordered garnishment(s) **Employee Work Schedule and Tasks**, DADS Form 1731
☐	**CLASS**	■	***CLASS ONLY:* Cardiopulmonary Resuscitation (CPR) Certification** – Effective at time of service delivery initiation and maintained; *Verify again before expiration date.* [Red Cross (one-year) or American Heart Association (two-year) Certification]
☐	**DADS**	■	**Texas Department of Public Safety Driver's License** (if transporting client) *Verify again before expiration date.*
☐	**DADS**	■	**Proof of Minimum Auto Insurance** (if transporting client)
☐	**CDC OSHA**	■	**Acknowledgement: Hepatitis B Vaccinations and Universal Precautions** – Center for Disease Control and Prevention and Occupational Safety and Health Administration, DADS Form 1727
☐	**TWCC**	■	**Notice to Employees Concerning Workers' Compensation in Texas** – Texas Workers' Compensation Commission (TWC Notice 5)
☐	**CDS DADS**	■	**Service Agreement between Employer and Employee**, DADS Form 1735; **Applicant and Employer Relationship Determination and Certification**, DADS Form 1734; and **Employer and Employee Exemption from Nursing License for Certain Services**, DADS Form 1733
☐	**DADS**	■	**Employee Management Form:** annual evaluation, employment status changes, documentation of training, documentation of conflict and job performance issues; client satisfaction; DADS Form 1732 (Copy to CDSA for schedule or wage changes, termination.)
ONGOING: (1) Original Employee Personnel File AND (2) Copy to CDS Agency			
☐	**DADS**	☐	**Timesheets**, DADS form or facsimile approved by the CDSA
☐	**Vendors**	☐	**Receipts** and **Invoices**

Code	Action
☑	Employer checks off each item for the **personnel file** and retains original or copy.
☑	Employer checks each required item when completed and sends to the CDSA as indicated. Employer retains original or copy.
■	Items the employer is **not** required to send to the CDSA, but **must** be maintained on file in the employee's **personnel file** by the employer.

Code	Agency
IRS	Internal Revenue Service
DADS	Texas Department of Aging and Disability Services
DPS	Texas Department of Public Safety
OSHA	Occupational Safety and Health Administration
CDC	Center for Disease Control and Prevention
OAG	Office of the Attorney General, State of Texas
TWCC	Texas Workers' Compensation Commission
USCIS	U. S. Citizenship and Immigration Services (formerly known as the **INS,** Immigration and Naturalization Services)

Texas Department of Aging
and Disability Services

Consumer Directed Services

Form 17**25**
August 2005

Criminal History and Registry Check

SECTION I – Applicant Authorization/Acknowledgment (Applicant must complete this section.)

I, (applicant's printed name) _____ , give authorization for a check of my criminal history and required registries in the course of applying for a position as either an employee or service provider in Consumer Directed Services (CDS). I also acknowledge that a conviction of a crime or registry listing that prohibits a person from employment in a health care setting in the state of Texas applies to this position. I also acknowledge that I may not be offered a position or provide services for payment before the required criminal history and registry checks are completed and comply with requirements, reviewed by the Employer **and** validated by the Consumer Directed Services Agency (CDSA).

Signature – Applicant | Date

Applicant Information Required by the Texas Department of Public Safety (DPS) (Applicant must print.)

Name: (Last, First, Middle)		
Alias:	Maiden Name:	
Date of Birth: (mm/dd/yyyy)	Race: (If not Black, check White) ☐ Black ☐ White	Social Security No.:

SECTION II – Criminal History Check and Registry Verification Process (Employer must complete this section.)

Employer Name:

Criminal History Check

☐ The applicant will provide a **current** Criminal History Check from DPS.

☐ I will acquire a **current** Criminal History Check of the applicant from DPS.

☐ I request that my CDSA acquire a **current** Criminal History Check of the applicant from DPS. I also authorize the CDSA to be reimbursed for the cost of acquiring the DPS Criminal History Check from my budgeted funds.

Registry Verification

☐ I will verify the applicant's current status with the state of Texas Employee Misconduct Registry and the Nurse Aide Registry.

☐ I request that my CDSA verify the applicant's current status with the state of Texas Employee Misconduct Registry and the Nurse Aide Registry.

Signature – Employer | Date

SECTION III – Criminal History and Registry Process Results (Employer or CDSA must complete this section.)

DPS Criminal Convictions Criminal History Check

Date of DPS Check:	Time: ☐ AM ☐ PM.	Verified By:

Convictions: ☐ **Yes** ☐ **No** Do the convictions prohibit employment? ☐ **Yes** ☐ **No**

Registry Checks (Call 1-800-452-3934)

Date of Registry Checks:	Time: ☐ AM ☐ PM	Verified By:

Employee Misconduct Registry: ☐ No Record ☐ Record (must not be hired)

Nurse Aide Registry: ☐ No Record ☐ Record (must not be hired)

CERTIFICATION – I acknowledge that the applicant's criminal history and registry record were checked. The employer and the CDSA have each been notified of the results of each check.

The applicant ☐ **is** ☐ **is not** eligible for hire based on the checks above.

Signature – CDSA Representative | Date

Signature – Employer | Date

Consumer Directed Services

Occupational Exposure to Bloodborne Pathogens

Universal Precautions

Blood has long been recognized as a potential source of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. Universal precautions is the method of control required by the Occupational Safety and Health Administration (OSHA) to protect employees from exposure to all human blood and body fluids. **Universal precautions** refers to a concept of bloodborne disease control, which requires that all human blood and certain human body fluids be treated as if known to be infectious for HIV (the virus that causes AIDS), the Hepatitis B virus and other bloodborne pathogens.

Protective barriers reduce the risk of exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks and protective eyewear. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand-washing and using gloves to prevent gross microbial contamination of hands. Universal precautions will be used during the provision of services as applicable and appropriate.

Employee Initials: _____ Date: _____

Hepatitis B

Hepatitis B is a serious infection involving the liver. Hepatitis B virus (HBV) can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure and death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. HBV is a major infectious occupational hazard for health care. Any health-care worker may be at risk for HBV exposure depending on the tasks that he or she performs. Workers should be vaccinated if their tasks involve contact with blood or blood-contaminated body fluids.

Employee Initials: _____ Date: _____

Hepatitis B Vaccination

OSHA standards effective June 4, 1992, require that employers make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure. The Hepatitis B vaccine is available at no cost to the employee. The cost to provide vaccinations is an administrative expense to the employer and is reimbursable through the consumer's program budget.

The vaccine is administered in a prescribed series of three injections over a six-month period:

Dose 2 is administered 30 days after Dose 1.

Dose 3 is administered five months following Dose 2.

The employee is responsible for requesting from the healthcare provider administering the vaccination additional information specific to the efficiency, safety, benefits, method of administration and potential side effects of the Hepatitis B vaccination.

The employee may elect to **receive** or **decline** the Hepatitis B vaccination.

Employee Initials: _____ Date: _____

Informed Choice Related to Hepatitis B Vaccination

Employee Statement — Check one statement below.

☐ I **agree** to receive the Hepatitis B vaccination and will be reimbursed by my employer within 30 days of presenting a paid receipt for each dose. I understand that I will only be reimbursed for doses received while employed by the employer.

☐ I **agree** to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination:

_____

_____

☐ I **decline** the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

☐ I **decline** the Hepatitis B vaccination.

* **I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.**

Federal Register: 61 FR 5507, February 13, 1996
*OSHA 1910.1030 App A – *Mandatory Declination Statement*

Certification by Employee:

I, _____ , the **employee**, acknowledge and certify that I have received information on occupational exposure to bloodborne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented above) related to the Hepatitis B vaccination based on informed choice.

* I may decide in the future to request and accept the vaccination at no charge to me.

Employee:	**Employer:**
Printed Name	Printed Name
Signature	Signature
Date	Date

Consumer Directed Services

Liability Notice to Employees

Employer Acknowledgement

The consumer, his/her court appointed guardian or parent of a minor is the employer in Consumer Directed Services (CDS). The employer retains control over hiring, supervision and management, and firing of employees.

The Consumer Directed Services Agency (CDSA), the Texas Department of Aging and Disability Services (DADS), any other state or federal agency, or any other contracted provider agency does **not** employ the employee(s) providing these services through CDS. The employer is solely responsible and liable for any negligent acts or omissions by the employer, the employee, other employees or service providers, the consumer or, if applicable, the Designated Responsible Party.

I acknowledge that I have read and understand information in the Employer Acknowledgement:

Signature – Employer	Date	Signature – Employee	Date

Liability Notice to Employees

Section I:

Employer indicates the correct option:

- ☐ I **AM** a subscriber of Texas Workers' Compensation through the Texas Workers' Compensation Commission (TWCC).
- ☐ I am **NOT** a subscriber of Texas Workers' Compensation through the TWCC. (Complete Section II below if you have chosen this option.)

Section II:

Employer indicates the correct option in this section if the employer is **NOT** a subscriber to Texas Worker's Compensation.

- ☐ I have made the following arrangement(s) for employee injuries/illnesses:
  - ☐ self-insurance;
  - ☐ homeowner's personal liability insurance;
  - ☐ renter's personal liability insurance;
  - ☐ medical coverage insurance; and/or
  - ☐ risk pool insurance.
- ☐ I have **NO** insurance or other protection against work-related injuries/illnesses for my employee(s).

Employee/Employer Acknowledgement

I acknowledge that I have read and understand the information in Liability Notice to Employees.

Signature – Employer	Date	Signature – Employee	Date

Consumer Directed Services
Applicant Verification

Consumer's Name	Employer Name
Applicant Name	Social Security No.
Date of Hire	First Schedule Day of Work

The employer must verify that the applicant meets each criterion. The employer must ensure the following forms and/or copies of documentation to verify the criteria are met and are kept in the employee's personnel file.

Employment Qualifications:

- ☐ The applicant is at least 18 years of age.
- ☐ The applicant is not disqualified based on Form 1726, Relationship Definitions in Consumer Directed Services.
- ☐ The applicant is not barred from employment based on the results of the Texas Department of Public Safety (DPS) Criminal Conviction History Check and Health and Safety Code 250.
- ☐ The applicant has read *Notice Concerning Workers' Compensation in Texas* (TWC Notice 5)
- ☐ Verification of New Hire Reporting, Office of the Attorney General/ State of Texas.
- ☐ Form 1727, page 2, Occupational Exposure to Bloodborne Pathogens
- ☐ Form 1733, Employer and Employee Exemption from Nursing License for Certain Services
- ☐ Form 1735, Employer and Consumer Directed Services Agency Service Agreement

CLASS Program ONLY: Continued Employment Qualifications:

☐ The employee is certified in Cardio-Pulmonary Recitation (CPR) at time of employment.

CPR Certification Effective Date:	Type:	Expiration Date:

☐ **Yes** ☐ **No** The employee is required to transport the CLASS consumer. If **yes**:

☐ The employee must a valid Texas driver's license.

Driver's License No.	State	Expiration Date:

☐ The employee must have the minimum required Texas liability insurance coverage.

Employer Certification:

The applicant ☐ **does** ☐ **does not** meet qualifications for employment.

Only applicants that meet **all** qualifications may be employed.

Acknowledgement:

The applicant and employer acknowledge that the applicant meets qualifications for employment. The employer has offered employment to the applicant. The applicant has accepted employment. The employer acknowledges that a copy of this form must be provided to the Consumer Directed Services Agency.

Signature – Employer	Date	Signature – Employee	Date

Texas Department of Aging
and Disability Services

Consumer Directed Services
Wages and Benefits Plan

Form **1730**
August 2005

Employee Name (Last, First, Middle Initial)		Social Security No.
Date of Hire	First Work Date	☐ Initial Wage and Benefit Plan ☐ Plan Change – Effective Date:

Compensation:

Regular Hourly Wage	**Calculation of Overtime Hourly Wage**
☐ Attendant = $ _____	Hourly $ _____ + $ 0.00 (50%) = $ 0.00
☐ Respite = $ _____	Hourly $ _____ + $ 0.00 (50%) = $ 0.00

Benefits: ***Optional***

☐ **Hepatitis B Vaccination** (Attach completed Form 1727 if vaccination is requested by the employee.)

Employer: List other optional benefits here. (Attach additional sheet, if required.)

Withholdings:

☐ **W-4 Employee's Withholding Allowance Certificate** (Attach completed Form W-4.)

☐ **Required Garnishments**

Type:	Amount:
Frequency:	Payment To: (Attach detail.)

☐ **Voluntary Withholdings** (not related to W-4)

Type:	Amount:
Frequency:	Payment To: (Attach detail.)

☐ **Other** (specify): _____ (Attach detail.)

Acknowledgement / Agreement:

Time Sheets must be completed accurately each work shift/day.

Accurate, signed time sheets are due: _____

Paychecks are distributed by (method): _____ at least twice a month on _____ **or** every other week starting _____ .

Employee and employer mutually agree to the compensation, benefits, withholdings and information above and agree that any changes or revisions must be documented and provided to the employee, the employer and the Consumer Directed Services Agency.

Signature – Employer	Date	Signature – Employee	Date

Texas Department of Aging and Disability Services

Consumer Directed Services

Form 1731
September 2005

Employee Work Schedule and Assigned Tasks

Employee Name: _____

☐ Initial ☐ Tasks

☐ Change ☐ Schedule Effective Date: _____

Schedule I _____

Day	Time In	Time Out	Time In	Time Out	Total Hours
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
				Weekly Total Hours	

Schedule I – Tasks

Schedule II _____

Day	Time In	Time Out	Time In	Time Out	Total Hours
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
				Weekly Total Hours	

Schedule II – Tasks

Acknowledgment of Work Schedule and Assigned Tasks – Sign and Date:

Signature – Employer	Date	Signature – Employee	Date

Texas Department of Aging
and Disability Services

Consumer Directed Services
Employee Management

Form **1732**
August 2005

Employee Name	Today's Date
First Day of Work	Annual Evaluation Due Date
Consumer Name	Employer Name

Purpose of Form:

☐ Evaluation ☐ 30-Day ☐ 3-Month ☐ 6-Month ☐ Annual ☐ Other: _____

☐ Supervision ☐ Verbal Warning ☐ 1st ☐ 2nd ☐ 3rd ☐ Other: _____

☐ Training ☐ Written Warning ☐ 1st ☐ 2nd ☐ 3rd ☐ Other: _____

☐ Conflict Resolution ☐ Other: _____

Satisfaction:

Is the **consumer** satisfied with the services provided by the employee? ..... ☐ **Yes** ☐ **No**

Is the **employer** satisfied with the services provided by the employee? ..... ☐ **Yes** ☐ **No**

Employer Comments:

Employee Response:

Agreement / Resolution:

Action Taken/Follow-Up Scheduled:

Acknowledgement/Agreement Between Employee and Employer:

Effective Date: _____ _____ _____

Signature – Employee | Date

_____ _____ _____ _____

Signature – Employer | Date | Signature – Witness/Other | Date

Consumer Directed Services

Employer and Employee Exemption from Nursing License for Certain Services

The following text is from the Government Code, Title 4, Subtitle I, Chapter 531, Subchapter B. §531.051, Voucher program for payment of certain services for persons with disabilities, states (in part):

(f) Section 301.251(a), Occupations Code, does not apply to delivery of a service for which payment is provided under the *voucher payment program developed under this section if:

(1) the person who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter 301, Occupations Code, that is revoked or suspended; and

(C) provides a service listed under Subsection (h); and

(2) the consumer who receives the service:

(A) has a functional disability and the service would have been performed by the consumer, or the parent or guardian for the consumer, except for that disability; and

(B) if:

(i) the consumer is capable of training the person in the proper performance of the service, the consumer directs the person to deliver the service; or

(ii) the consumer is not capable of training the person in the proper performance of the service, the consumer's parent or guardian is capable of training the person in the proper performance of the service and directs the person to deliver the service.

(g) If the person delivers the service under Subsection (f)(2)(B)(ii), the parent or guardian must be present when the service is performed or immediately accessible to the person who delivers the service. If the person will perform the service when the parent or guardian is not present, the parent or guardian must observe the person performing the service at least once to assure the parent or guardian that the person performing the service can competently perform that service.

(h) The types of services that may be delivered under Subsection (f) are:

(1) bathing, including feminine hygiene;

(2) grooming, including nail care, except for clients with medical conditions like diabetes;

(3) feeding, including feeding through a permanently placed feeding tube;

(4) routine skin care, including decubitus Stage 1;

(5) transferring, ambulation, or positioning;

(6) exercising and range of motion;

(7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation, and digital stimulation; and

(8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube.

Certification – I certify that I have read and understand the above information. I understand that the employer may train and supervise me, the employee, in the delivery of the services listed in item (h) without the involvement of a licensed nurse. I understand that the employer may choose to train and supervise me on those tasks.

Employee:	**Employer:**
Printed Name	Printed Name
Signature	Signature
Date	Date

Texas Department of Aging
and Disability Services

Consumer Directed Services

Form **1734**
August 2005

Applicant and Employer Certification of Relationship for Employment

Applicant Name	Maiden Name	Applicant Social Security No.
Consumer Name	Employer Name	
Designated Responsible Party (DRP), if applicable		

Applicant: Place a check mark in the column that describes your relationship.

Yes	No	N/A		Relationship
All Programs – Status of these relationships must be certified by *each* applicant:				
☐	☐		1.	Are you *under* the age of 18?
☐	☐		2.	If the consumer is under the age of 18, a minor, are you his/her natural parent, court-appointed guardian, legal/adopted parent or stepparent?
☐	☐		3.	If the consumer is under the age of 18, a minor, are you the *spouse of his/her natural parent, court-appointed guardian, legal/adopted parent or stepparent?
☐	☐		4.	If the consumer is 18 years of age or older, are you the court-appointed guardian?
☐	☐		5.	Are you the *spouse of the consumer's court-appointed guardian?
☐	☐	☐	6.	Are you the *spouse of the consumer? [**CMPAS = N/A]
☐	☐	☐	7.	Are you the *spouse of the employer? [**CMPAS = N/A]
☐	☐	☐	8.	If the consumer is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you his/her foster parent? If the consumer is not with DFPS, mark this item N/A.
☐	☐	☐	9.	If the consumer is a DFPS foster child or adult, are you the *spouse of his/her foster parent? If the consumer is not with DFPS, mark this item N/A.
☐	☐		10.	Are you the power of attorney (POA), attorney in fact or agent for the consumer?
☐	☐		11.	Are you the *spouse of the consumer's power of attorney (POA), attorney in fact or agent for the consumer?
☐	☐		12.	Are you the Designated Responsible Party (DRP) for the consumer or the employer for Consumer Directed Services?
☐	☐		13.	Are you the *spouse of the employer's DRP?
Medically Dependent Children Program (MDCP) must **also** respond to the following relationships:				
☐	☐		1.	Are you the parent, primary caregiver or other individual living in the same household as the consumer?
☐	☐		2.	Are you the *spouse of the parent, primary caregiver or other individual living in the same household as the consumer?
Primary Home Care (PHC) Program must **also** respond to the following relationships:				
☐	☐		1.	Are you the primary caregiver for the consumer in either PHC Community Attendant (CA) or PHC Family Care (FC)?
☐	☐		2.	Are you the *spouse of the primary caregiver for the consumer in either PHC CA or FC?

* **Spouse** is defined as either a *legal marriage* **or** a *marriage without formalities* (common law marriage).

** The spousal relationship is not applicable (N/A) for Consumer Managed Personal Assistant Services (CMPAS).

Employer and Applicant Certification:

If any item above is marked "Yes," the applicant is *not* eligible for employment. The applicant is not eligible by relationship in Consumer Directed Services (CDS) for this consumer.

If each/every item above is marked "No" or "N/A," the applicant meets relationship eligibility for employment in CDS for this consumer. (N/A applies only to CMPAS for Items 6 and 7 **and** only to individuals not in DFPS for Items 8 and 9.)

Employer certifies that this Applicant ☐ **is** or ☐ **is not** eligible for employment in CDS for this consumer.

Printed Employer Name	Signature – Employer	Date
Printed Applicant Name	Signature – Applicant	Date

Consumer Directed Services

Employer and Employee Service Agreement

The name of individual receiving services, hereafter referred to as the "**Consumer**," is: _____ .

The Consumer's program, _____ , hereafter referred to as the "**program**," is funded and administered by the Texas Department of Aging and Disability Services (DADS).

The name of the employer, hereafter referred to as "**Employer**" is: _____ _____ The Employer is the ☐ Consumer, ☐ parent of a minor or ☐ court-appointed guardian of the Consumer.

This agreement is between the Employer and _____ hereafter referred to as "**Employee**."

The Employer Agrees:

1. To give notice to the Employee as soon as possible of any change(s) in the work schedule, the tasks to be performed or the number of hours the Employee will work.
2. To adhere to all federal, state, and local employment-related laws and regulations.
3. To assume responsibility for:
   a. liability for any negligent acts or omissions by the Employer, his/her Employee(s) and service provider(s), the Designated Responsible Party (if applicable), the Consumer or others in the work place; and
   b. managing the risk and liability of any incidence(s) of Employee work-related injury/injuries or illnesses.
4. To provide orientation and training to the Employee of tasks and activities to be performed.
5. To provide the Employee with written notice of compensation for services delivered.

The Employee Agrees:

1. I, _____, the Employee, am willing and able to perform the tasks as outlined by, and at the direction of, the Employer, the Consumer or the Designated Responsible Party, if applicable.

2. To provide information and documents to the Employer, as required, to maintain current, up-to-date personnel records. The information and documents include at least changes in address and/or telephone numbers, criminal convictions and evidence of employment status and qualifications.

3. To not use the personal property of the Employer or the Consumer without prior approval. The Employee will reimburse the Employer for any expense incurred related to his/her personal use of the personal property.

4. To respect the rights and dignity of the Consumer and to follow safety procedures for the benefit of the Consumer and the Employee.

5. To notify the Employer as soon as possible when the Employee will be late for work or is not able to work, as well as not report to work when illness or another condition may jeopardize the health and safety of the Consumer.

Both the Employer and the Employee Agree:

1. That this document serves as an agreement, not an employment contract.
2. That the Employer employs the Employee. The Employee is not an independent contractor. The Employer controls the training and management, evaluation and firing/termination of the Employee.
3. That the Employee is not barred by relationship to the Consumer, Employer or Designated Responsible Party, if applicable, from being an Employee.
4. That a Consumer Directed Services Agency (CDSA) is responsible for the administration of program funds on behalf of the Employer, including payroll functions.
5. That funding for services to pay the Employee is from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the Employee have an individual and joint responsibility to account for the use of public funds.
6. To provide an accurate accounting of services delivered by the Employee, and to submit accurate time sheets and documentation for reimbursement to the CDSA.
7. To bill only for actual time worked, allowable benefits and CDS-related expenses (billing for services and items not allowed or budgeted results in non-payment by the CDSA).
8. The Employer must not charge any fee to the Employee. The Employee must not make any payment to the Employer related to the Employee's employment. Any corrections to payroll are made by the CDSA.
9. That neither the CDSA or DADS is responsible or liable for any negligent acts, work-related injuries or omissions by the Employer, Consumer, Employee, other Employees and service providers and/or the Designated Responsible Party, if applicable.
10. That personal medical and personal information and data about the Consumer and the Employee is confidential. This information is not to be discussed, directly or indirectly, with others outside of the work environment at any time, currently or in the future.

Duration and Modification of Service Agreement

1. This service agreement will be in effect as of the date this agreement is signed by the Employer and Employee. This service agreement must not precede the date the Consumer is eligible to participate in the program or in Consumer Directed Services.
2. This service agreement can be modified by agreement of both parties, unless prohibited by DADS rules or policy, or by applicable state, federal and/or local regulations.
3. This service agreement will terminate when:
   a. the Consumer’s participation in Consumer Directed Services ends voluntarily or involuntarily;
   b. the client is no longer eligible for the DADS program or for CDS participation;
   c. the Employee is convicted of a crime or listed on a registry that forbids employment by law;
   d. a relationship change occurs and continued employment is prohibited; or
   e. the Employee fails to maintain and provide documentation of eligibility or qualifications for continued employment.

4. This service agreement may be terminated, without cause, by either party with 14-calendar days written notice. A different time frame may be used if both parties agree in writing.

The following required documents are incorporated by reference:

Document	Date of Signatures
DADS Form 1725, Criminal History and Registry Check	
Criminal Convictions History Report from the Texas Department of Public Safety (DPS)	
DADS Form 1729, Applicant Verification	
DADS Form 1733, Employer and Employee Exemption from Nursing License for Certain Services	
DADS Form 1734, Applicant and Employer Certification of Relationship for Employment	

Acknowledgement of service agreement, including documents incorporated by reference:

Employer:

Printed Name

Signature

Date

Employee:

Printed Name

Signature

Date

Application

Date of Application: _____/_____/_____

Name:_____
(Last) (First) (Middle Initial)

Social Security #: _____ Phone #: (___)_____

Date of Birth:_____

Address: _____
(Street) (City) (State) (Zip Code)

Position Applied For: _____ Full-time? [ ]Y [ ] N
Days Available: _____ Part-time? [ ]Y [ ] N
Hours Available: _____

1. Are you eligible for employment in the United States? [ ] YES [ ] NO
   (I understand that if I am hired, I will be required to provide proof of identity and legal work authorization.)
2. Have you ever had a criminal conviction? [ ] YES [ ] NO
   If yes, please explain: _____
3. All positions require drug screening. Do you consent to the testing prior to beginning work? [ ] YES [ ] NO
4. Will you work overtime if asked? [ ] YES [ ] NO

If you answered NO to questions 1 or 4, please explain: _____
_____

EMPLOYMENT EXPERIENCE:

Employer: _____
Address: _____ Phone: _____
Supervisor: _____ Job Title: _____
Dates of Employment: From: Mo./Yr. _____To: Mo./Yr. _____
Starting Hourly/Salary Rate: _____ Ending Hourly/Salary Rate: _____
Work Performed: _____
Reason for Leaving: _____
May we contact your present employer? [ ] Yes [ ] No

Employer: _____
Address: _____ Phone: _____
Supervisor: _____ Job Title: _____
Dates of Employment: From: Mo./Yr. _____To: Mo./Yr. _____
Starting Hourly/Salary Rate: _____ Ending Hourly/Salary Rate: _____
Work Performed: _____
Reason for Leaving: _____
May we contact your former employer? [ ] Yes [ ] No

Employee Orientation Acknowledgement

Material Covered	**Time Spent**
Consumer Directed Care	**35 Minutes**
CLASS Service Delivery Model	**10 Minutes**
Mission and Objectives	**10 Minutes**
Glossary of Terms	**10 Minutes**
People First Language	**15 Minutes**
Quality of Life	**10 Minutes**
Listening skills	**15 Minutes**
	25 Minutes
Overview of Related Conditions	
CLASS Program	**5 Minutes**
Overview Cerebral Palsy, Spina bifida, Head and spinal cord injuries, muscular dystrophy, epilepsy, autism, etc.	**40 Minutes**
Commonly Provided Task	
Feeding, bathing, dressing, toileting, transfers, exercise, transporting, fostering independence, etc.	**60 Minutes**

Employee Signature: _____ Date _____

Job Description

Habilitation Attendant

I. Summary of Position

Working with Participants to help them become as independent as possible.

II. Qualifications

A. Be at least 18 years of age
B. Be neither legal nor foster parents of the minor child receiving the service
C. Not be spouse of the Participant receiving the service

III. Description of Duties and Responsibilities

A. Working with Participant's schedule
B. Documentation of habilitation work done

The following are based on the Participant's IPP goals:

A. Knowledge of the CLASS program
B. Perform personal care tasks as necessary
C. Health related tasks as necessary
D. Food and nutritional assistance as necessary
E. Money management as necessary
F. Household tasks as necessary
G. Community integration assistance as necessary
H. Assistance with personal decision making
I. Assistance with facilitation of self advocacy
J. Assistance with leisure time and recreational activities
K. Follow-up with any therapy goals as directed
L. Any other tasks as dictated by the IPP goals

IV. Performance Requirements

A. Compliance with guidelines of CLASS Manual
B. Current CPR certification

_____ _____

Employee Signature Date