MyCare Ohio Program
Employer/Employee Agreement Form

Consumer/Employer Name (please print) _____ ID #_____
Consumer/Employer Name Consumer/Employer ID #

Provider/Employee Name (please print)_____
Employee Name

Provider/Employee Address _____
Number Street Unit/Apt

_____
City State Zip

Provider/Employee_____Home_____Phone:
Provider/Employee_____Cell_____Phone:
Provider/Employee Email Address: _____

Are you interested in being listed on the Provider/Employee registry so your information can be provided to other potential Consumer/Employers in this Choices program that are looking to hire? _____
Please state yes or no

If yes, Morning Star will contact you either by phone or your email address listed above to provide you with the additional information about the registry.

Y **N** Are you the spouse of the Consumer/Employer?

Y **N** Are you the parent of the Consumer/Employer?

Y **N** Are you the child of the Consumer/Employer?

Y **N** Are you under the age of 18?

Y **N** Are you related to the Consumer/Employer in anyway? If yes,

Please state relationship here:_____

The above questions are asked to determine which tax laws and/or exemptions may apply to you as the Provider/Employee. They also help ensure compliance with program rules.

The Provider/Employee agrees to accept payment for services provided for individuals served through the MyCare Ohio Program. Fiscal management services are provided by Morning Star, which is not an Ohio government agency. Acceptance and endorsement of payment will signify that the Provider/Employee agrees to the following terms and conditions:

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1. I understand that all required enrollment paperwork must be completed and processed before I can receive payment for services provided.
2. I understand and acknowledge that neither the OH Department of Aging nor Morning Star or any health plan, is the Consumer/Employer and that they are not responsible for the actions of the Consumer/Employer.
3. I agree not to accept compensation for service provided above and beyond the authorized rate that my Consumer/Employer has on record with Morning Star.
4. I will provide only the services that have been approved by my Consumer/Employer and authorized in the Consumer/Employer's Service Plan.
5. I recognize that employment is dependent on the Consumer/Employer's participation in the MyCare Ohio Waiver Program.
6. I will complete and keep current any individualized training recommended by the Consumer/Employer and/or required by the MyCare Ohio Waiver Program.
7. I understand and acknowledge that any untruthful report of services provided in an attempt to obtain improper payment is subject to investigation as Medicaid fraud. Medicaid fraud is a felony and can lead to substantial penalties and/or imprisonment.
8. I acknowledge that federal income tax withholding, Medicare, social security, and state and local income tax withholding (as applicable) shall be withdrawn from my wages per state and federal laws.
9. I understand and acknowledge that work performed in excess of the authorized amount or service limitations will not be paid for by The MyCare Ohio Waiver Program or Morning Star.
10. I understand and acknowledge that, should I be paid in excess of what is allowable by the program, it may be deducted from my future payroll check(s).
11. I agree to maintain confidential all information regarding the Consumer/Employer, their Authorized Representative, if applicable, and his/her family.
12. I agree to immediately notify a person designated by the Consumer/Employer of any medical emergency, illness, medical treatment.
13. I agree to immediately notify the appropriate authorities with any suspicion of abuse or neglect of the Consumer/Employer.

By signing below, I acknowledge that I have read this Employer/Employee Agreement in its entirety (2 pages). I understand that I must sign and return both pages as a condition of employment in this program and that I cannot begin working in the MyCare Ohio Waiver Program until this form is completed and returned to Morning Star. By signing below, I further acknowledge that I understand what is being required of me, and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and/or conditions of this agreement may result in termination of this agreement and payment for employment to any Medicaid Recipient of this program.

Provider/Employee signature Date

Consumer/Employer and/or Authorized Representatives signature Date

Case Manager Signature Date