Service Agreement Form Instructions

Introduction to the Provider Service Agreement

The Provider Service Agreement Form (Service Agreement) (DHS4606) is a tool designed to assist the person directing services, providers, and case managers in getting services to individuals through ODDS programs. When used correctly, it fulfills the Federal and administrative rule requirement for a provider to agree, in writing, to implement the services chosen by the individual and authorized in an ISP. For this reason, it is critical that the content of the service agreement aligns with that of the ISP.

The Service Agreement outlines the services that the Case Management Entity has authorized in an ISP for a provider to deliver. A complete ISP can substitute for a Service Agreement form when the chosen provider has signed it, been given a copy, and is not a PSW. Any provider who has a Medicaid provider number (i.e. is enrolled in eXPRS) must have a signed ISP or service agreement form for each service they are paid to deliver. When a provider does not sign an ISP or service agreement prior to the delivery of services, the provider may not receive payment for the services.

Full ISP or Service Agreement?

The individual receiving services, or the legal guardian, **always** has the right to restrict or give access to their ISP to those people they want to see it. If the individual or guardian chooses to not to share their ISP then a Service Agreement must be created.

When a Service Agreement form must be completed

A Service Agreement form must be completed if:

- The provider of services is a Personal Support Worker.
- The provider of services is a non-Personal Support Worker Independent Provider or Agency AND the individual or guardian has not given permission to share a full copy of the ISP. A full copy of the ISP includes: The ISP, the Career Development Plan (if an employment service), the Risk Management

Plan and supporting documents (protocols, behavior support plans, nursing care plans, etc.)

The Service Agreement form has two components: *ISP Services Authorized* and a *Provider Addendum*. The Case Management Entity is responsible for fully completing the ISP Services Authorized component of the Service Agreement. The Provider Addendum is then attached to the ISP Services Authorized portion and sent for signatures. Once completed, it gets returned to the case management entity and filed with the ISP.

Section 1 - ISP Services Authorized

First, choose the type of provider subject to the agreement. The choice will associate the proper addendum for the agreement.

Dates of Service

The Dates of Service on the Service Agreement are the dates that the case manager has authorized the provider to deliver services. Both the Start and End date are 'to not exceed' dates, or dates the provider cannot work before or past.

The Start and End dates are the absolute limits for the Service Agreement; however, they work in conjunction with the signature dates. Until a Service Agreement is signed and dated by all required parties, it is not valid. As such, even though the start date of Service Agreement may be on the 1st of the month, if the agreement is not signed until the 5th of the month, it is not in effect until the 5th of the month. Use the table below to help you determine the start date of services:

All Signature Dates	Start Date
Prior to the Start Date on the Service Agreement	The Start Date on the Agreement
On the Start Date on the Service Agreement	The Start Date on the Agreement
After the Start Date on the Service Agreement	The Latest Signature Date on the Agreement

The end date of the service agreement is the day the authorization for the service ends as reflected on the ISP. A provider may not work when services are not authorized. The date may not be beyond the end date of the current ISP. If a provider starts work in the middle of the ISP year the end date would be the end of the current ISP even though that may only be a short time later.

Credential Lapses

If a provider's credentials lapse during the service agreement period they are not authorized to deliver services. If the provider re-establishes their credentials they can restart services from the first date of their newly established credential. A new Service Agreement is not required.

As a best practice, the start date of service lines in eXPRS Plan of Care should align with the start date of the signed service agreement. If it does not, the service line should not be put into accepted status until the services have been agreed to in writing. Any services delivered prior to the start date of the service agreement are not considered authorized for payment. Exceptions due to emergent circumstance will be considered by the Department on a case by case basis.

If a single service agreement is used for more than one service and the dates of the different services are not the same, identify the effective dates for each service in the Description of Medicaid Tasks Authorized text box. For example, initial and on-going job coaching may both be covered by one agreement, but the start and end dates will be different for both. The start and end dates of this part of the form will be the start date for the initial job coaching services and the end date of the on-going job coaching (or the end of the ISP).

General Information

The Demographics section identifies:

- Name of the individual receiving services,
- PRIME number of the individual receiving services,
- Provider's name/ agency,
- Provider's SPD provider number,
- The Authorizing Agency (Your Agency Name),

- Name of Services Coordinator or Personal Agent, and
- Contact Information of the Services Coordinator or Personal Agent

Description of Services

The Description of Services identifies the services the provider has been authorized to deliver.

Service and proc codes table

The Service Table contains the financial elements of the service agreement. There are four components, Service and Proc Code, Rate of Pay, Units Authorized, and Frequency.

Service and Proc Code

Service and Proc Code is the area in which you identify what services the provider will be performing. This must match the codes in eXPRS and the ISP.

Units Authorized

The units authorized are the maximum number of units you are authorizing to the provider based on frequency. Units are a measure of what is allocated to the provider. This may be in hours or other units. For example, a Personal Support Worker allocated 40 units per week is 40 hours per week. An agency allocated 1 unit per year for family training is being allocated a unit of service (an event), not an hour of service.

When completing this section and allocating hours you must not exceed any restrictions that are in place from the Department (e.g. 50 hours per week). As stated in the Addendum, the hours allocated are 'not to exceed.' The actual work hours of the PSW are directed by the Employer.

Frequency

The frequency is how often the service takes place. For flexibility, this can be set to Daily, Weekly, Monthly, or Yearly. The frequency must match the frequency in eXPRS.

The service table can be expanded to include multiple lines. Click on "Add a New Row" to add lines to the table.

When can I tell if I need to use separate Service Agreements?

It's always safe to use one service agreement per authorized service. You shouldn't feel that you have to jam all of them onto one form. The "Add New Row" is there to assist you for those services that are linked and it wouldn't make much sense to authorize on a separate form.

Desired Outcomes

This is an open field to describe to the provider how the duties and tasks identified in the next field help a person move towards their desired outcomes. For more information about desired outcomes, refer to the Oregon ISP Manual. It should convey to the provider why they are being asked to deliver the services in the agreement. Relevant desired outcomes from the ISP may be carried over, or may be customized here for a specific provider, yet in line with a desired outcome from the ISP.

Fundamental duties and tasks of the provider

These are open fields where the bulk of the specific information that a provider, employer, or person directing services needs to know will go. They should be freely used for instructions, conditions, unique considerations, etc. They can call attention to protocols or specific care giving needs.

The description of fundamental duties and tasks is where the case manager, as the authorizer of Medicaid services, outlines the tasks that the provider will be performing and how they relate to the individual goals and support needs.

This is not a Job Description in the traditional sense. For some very limited purposes, primarily for the determining coverage for workers compensation insurance, the Service Agreement Form may be referred to as a "job description."

The table on the next page outlines the differences between a traditional Job Description and a Description of Medicaid Tasks.

Description of duties and Tasks	Job Description
• Flows directly from the ISP, must contain the Medicaid authorized services the provider will be delivering • Does not contain scheduling • Includes rate of pay, units authorized, frequency and Medicaid Coding (captured in the Service Table) • Responsibility of the Authorizer of Medicaid Services	• Lines out scheduling, requirements for hiring, expectations around service delivery • Developed outside of the Service Agreement but can be attached • Responsibility of the Employer • Is smoking permitted? Can the provider bring their pet? • Encouraged, but not required.

The contents should align to identified support needs and be consistent with the ISP. It should include all the information the provider needs to perform the service, and all of the information that the employer and/or person directing the plan need to know to get the services delivered within the conditions that apply to a particular service. The tasks described should be specific enough that it is possible to know when a provider is doing something they are eligible to be paid for (and in the case of a PSW, whether they are covered by worker's compensation insurance if they are injured) and when they aren't.

For example, stating that the provider will do, "ADL and IADL supports to support Sam," is not sufficient. Rather, the ADL and IADL supports that are included in the Service Agreement should be specifically related to those areas of need identified through the assessment and person-centered planning process and documented on the ISP.

The summary section of the ISP may be attached and substitute for this section when it is sufficiently detailed for a provider to understand the scope of the services they are engaged to deliver. Reference to an attachment must be made here.

The contents can vary greatly and is a place to include details all people involved in the plan. If a provider needs to know that initial job coaching is only available for the first three months of the agreement, and ongoing job coaching is only available for the last nine months, that should go here. If the provider and person directing the plan needs to know that there are other providers who may also be getting a share of the authorized units of services, that should go here (for example, an individual may need a total of 100 hours per month of in home attendant care and may need the flexibility and safety of the availability of two provider agencies. Both may be authorized to provide up to 100 hours of supports, but the combined amount of services from each won't go over 100 hours).

Required Disclosures

There are two required disclosures, for employment services, the Career Development Plan, and for all services, any Identified Risks.

Career Development Plan Disclosure

If the service authorized is an employment support the Case Management Entity must give a copy of the Career Development Plan that was created as part of the ISP to the provider. This disclosure must be made at the same time that the Service Agreement is given to the provider.

Identified Risks

The Identified Risks are brought over from the Risk Management Plan from the ISP. **Any** risks identified on this plan that are **relevant** to the performance of the provider must be disclosed to the provider prior to signing the Service Agreement.

The Risk Management Plan may be used as the disclosure by attaching it to the service agreement form. If any of the following exist, they must be given to the provider as well:

- Protocols
- Safety plans
- Physicians Orders
- Nursing Care Plans
- Behavior Support Documents

The person receiving services has the right to refuse to disclose information. If they refuse to disclose identified risks, the provider must be notified that risks exist and that the individual is choosing not to disclose information about the risk(s). Do not disclose any specific risk without the permission of the individual.

For more information around this requirement please reference OAR 411-415-0080(5).

Section 2 – Provider Addendums

There are two provider addendums, the Personal Support Worker Addendum and the Non-PSW Independent Provider/Agency Addendum.

Personal Support Worker Addendum

This addendum must be attached to the ISP Services Authorized and given to the Personal Support Worker and Employer for review and signature prior to services starting.

The last page of the form for a PSW must be completed and attached to the agreement when the individual meets the criteria for enhanced or exceptional supports. It must also be given to any PSW if the individual is found to meet the enhanced or exceptional criteria after the agreement is already in place. If or when the PSW has the required training to receive the higher rate from enhanced or exceptional care, the PSW must complete, sign and return the form to the CME.

Provider Agency/Non-PSW Independent Provider Addendum

The addendum must be attached to the ISP Services Authorized and given to the Agency and person receiving services or their representative to sign. The Agency Representative is someone who has the authority to sign the Service Agreement on behalf of the agency. The person receiving services may name a designated representative to sign this document if they are unable to.

Responsibilities of the Authorizer of Medicaid Services, Employer, and Individual

- Authorizer of Medicaid Services (CDDP/Brokerages/CIIS)
    - Complete the ISP Services Authorized Section
    - For a Personal Support Worker
        - Attach the Personal Support Worker Addendum
        - Provide the Service Agreement form to the Employer for signatures
        - Authorize services in eXPRS-Plan of Care upon return of the signed Service Agreement
        - Provide a copy of the signed agreement to the Employer and PSW
        - Maintain a copy of the signed agreement with the ISP in the individual's file
    - For an Agency/Non-PSW Independent Provider
        - Attach the Agency/Non-PSW Independent Provider Addendum
        - Provide the Service Agreement to the Agency and Individual or Individual's Representative for signatures
        - Authorize services in eXPRS-Plan of Care upon return of the signed Service Agreement
        - Provide a copy of the signed agreement to the Agency and person receiving services
        - Maintain a copy of the signed agreement with the ISP in the individual's file
- Employer/Individual
    - For Personal Support Workers
        - Ensure that the appropriate people sign the Service Agreement and submit the completed Service Agreement to the Case Management Entity
        - Ensure that services are delivered as outlined in the Service Agreement and that workers do not exceed the amount of hours or units authorized in the Service Agreement

- Develop a Job Description for the Personal Support Worker (this may be done with the assistance of the Case Management Entity and/or attached to the Service Agreement). This does not replace the Description of Medicaid Services Authorized.
- Locate, screen, and hire a worker; supervise and train the worker; schedule work, leave, and coverage; recognize, discuss, and attempt to correct any performance deficiencies and provide appropriate, progressive, disciplinary action as needed; and discharge an unsatisfactory worker.

- For Agencies/ Non-PSW Independent Providers
  - Ensure that the appropriate people sign the Service Agreement and submit the completed Service Agreement to the Case Manager
  - Ensure that the services are delivered as outlined in the Service Agreement to their satisfaction

Special Circumstances

Behavior Support Services

If authorizing Professional Behavior Services, the following additional steps should be followed:

Description of Medicaid Tasks: Each distinct consulting task must be clarified separately (TESP/FBA/PBSP/Maintenance of the PBSP) along with clarification of the expectations for delivery of the final product/deliverable and the total hours being allocated to each portion of Professional Behavior Services. It is the responsibility of the case management entity to read each deliverable and, with the ISP team, decide if additional Professional Behavior Services are indicated.

Units Authorized: The case management entity authorizes one unit for each component (TESP, FBA or PBSP) of Professional Behavior Services. The cost of each Professional Behavior Service is calculated hourly not to exceed the expenditure guidelines.

Rate of pay must be consistent with the published expenditure guidelines.

Community Nursing Services

A nurse who is being referred using Form 0753, does not need a service agreement form if the completed Form 0753 is attached to the service agreement form and the box on that form labeled **Information LTCCN provider should know** is completed with known risks or the box is checked and the Risk Management Plan is attached.

Revisions

Service Agreements will need to be revised from time to time to meet the needs of the person served. An ISP change form that adequately describes the changes to the portions of the active service agreement, when signed by a provider – including a PSW – can function as the documentation of the revision.

Revisions fall into three categories:

- Add – Add a new service to the service agreement performed by the same provider.
- Remove – Remove a service from the service agreement but keep the other services in place.
- Modify – Change some element of the service authorized to the provider. Service Agreements can be changed to:
    - Adjust the number of units authorized to the provider
    - Adjust the tasks authorized to the provider in a service category

Terminations

No signatures from a provider or common law employer are required to terminate an agreement, however circumstances and the decision to terminate the agreement must be documented in the individual's progress notes.

Definitions

Case Manager – The Services Coordinator or Personal Agent who works with the person receiving services.

Common Law Employer – The person identified as the Employer of Personal Support Workers. Also may be referred to as an Employer of Record or EOR.

Case Management Entity – The Case Management Entity is the authorizer of Medicaid Supports. This would be a CDDP, Brokerage or CIIS.