

CENTER FOR LIVING & WORKING, INC.



Participant Guide to the MassHealth Personal Care Attendant Program

Last Update- 11/2019

Our Core Commitments:

The nonprofit Center for Living & Working (CLW) stands at the vanguard of the Independent Living movement. Founded in 1975, we now serve thousands of people in 70 cities and towns in Central Massachusetts, through Independent Living programs and services, resources for the Deaf and Hard of Hearing, and outreach and advocacy. All of CLW's programs and services express our philosophy: People with disabilities have the right to make informed decisions about their daily lives. Extending from this philosophy are our core commitments:

- To listen to consumers and offer encouragement in the quest for Independent Living.
- To offer information and programs that enable people with disabilities to live as independently as possible.
- To provide services that addresses the details of daily life.
- To help ensure that our consumers can participate as vital members of the community.

How to reach your Skills Trainer

Your Skills Trainer is the person to call when you are having a problem running your program, or when you have new needs to be addressed. In most cases, this will be the person who came to your home to help you understand how the PCA Program works when you first applied for services.

If you have issues regarding PCA payroll, you will need to contact the Fiscal Intermediary, Stavros Center for Independent Living. The Personal Care Management (PCM) Program staff members cannot assist with payroll issues.

While it is preferable to speak to your own Skills Trainer, any Skills Trainer can assist you if your issue cannot wait for your assigned trainer to return your call. Each of the PCM Program staff members have individual voicemail where you can leave a message if the person you are trying to contact is not available to take your call.

Center for Living & Working, Inc.	<u>Your Fiscal Intermediary is:</u> Stavros Center for Independent Living, Inc.
<p>Main Contact: 484 Main Street, Suite 345 Worcester, MA 01608 Telephone: (508) 798-0350 or (800) 570-4020 Fax: (508) 755-1072 TTY: (508) 755-1003 VP: (508) 762-1164</p> <p>Web Site: www.centerlw.org</p>	<p>Main Contact: 210 Old Farm Road, P.O. Box 2130 Amherst, MA 01004 Telephone: (413) 256-6692 or (800) 442-1185 Fax: (413) 256-3849</p> <p>Web Site: http://www.stavros.org</p>

INTRODUCTION:

MASSHEALTH PERSONAL CARE ATTENDANT (PCA) PROGRAM

The Personal Care Attendant (PCA) Program is a Medicaid-funded program that is available to anyone with a permanent or chronic disability who lives in a home environment and needs hands on personal care for at least two activities of daily living such as bathing, toileting and medication assistance. If necessary, time for instrumental tasks such as laundry, shopping, housekeeping, meal preparation and clean up can be incorporated along with the personal care.

Consumers are the employers of the PCA's (personal care attendants) whom they hire, train and manage. This is a consumer run program and requires your full participation. A surrogate can be used to assist with any aspects of the program that cannot be managed independently. An Administrative Proxy can be named to perform certain administrative tasks as identified by the consumer.

Your primary care physician is a vital link in the process and can greatly influence the time it takes to get on the program. Your physician may be required to provide documentation substantiating your need for this service and must sign the evaluation that is conducted by a Registered Nurse and an Occupational Therapist.

Skills Trainers are trained professionals who provide you with the knowledge and resources you will need to successfully manage your PCA Program. The Personal Care Management (PCM) Program staff are available to answer all your questions and provide you with support and training.

This manual explains all aspects of the program, the Medicaid regulations, information about the Fiscal Intermediary (FI) that will process the activity sheets, employee information and taxes, and paychecks to the PCAs.

The CLW Personal Care Management Program staff members are dedicated to provide quality services to all our consumers.

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Section I: Introduction to PCA Program

Section I: Introduction to the PCA Program

A: OVERVIEW OF CLW SERVICES

The Center for Living and Working, Inc. (CLW) is a private, nonprofit independent living center offering services that enable people with disabilities to live as independently as possible. The agency operates with the belief that people with disabilities have the right to make informed decisions regarding their own daily lives. Services are offered in approximately 70 cities and towns within the Central Massachusetts area.

CLW provides four core services to individuals with disabilities including individuals who are deaf or hard of hearing. Those services include skills training, information and referral, advocacy, and peer counseling. CLW offers innovative programs and services in addition to the four core services. Of those, CLW provides Personal Care Management (PCM) skills training to individuals who are MassHealth eligible.

B: DESCRIPTION OF MASSHEALTH PCM SERVICES

What is PCM?

CLW conducts an initial evaluation, annual re-evaluations and provides management training for consumers who are eligible for PCA services. Consumers receive training on how to recruit, interview, hire, train, supervise and dismiss PCAs, allowing consumers both the rights and the responsibilities of independence. The consumer is the employer in this relationship. PCAs work directly for the consumer and provide help in activities of daily living (ADLs) such as bathing, toileting, dressing, eating and household chores. CLW provides Personal Care Management services in Central Massachusetts.

What is a PCA?

Any individual, who is hired, trained and supervised by the consumer to provide personal care attendant services shall be referred to as a PCA.

What are Personal Care Services?

Personal Care Services include assisting the consumer with activities of daily living (ADLs) such as bathing, dressing, toileting, eating and other related personal functions.

They also include household chores such as meal preparation, laundry, shopping, housekeeping and other activities called instrumental activities of daily living (IADLs). These services assist the consumer to be as independent as possible in their communities.

Who Determines How Many Hours of PCA Services a Consumer Receives?

The number of hours of PCA services is proposed through a MassHealth Evaluation conducted by a Registered Nurse (RN) and an Occupational Therapist (OT). The evaluation is then submitted for review and signature by the consumer's Primary Care Physician and sent to MassHealth for consideration. The MassHealth Prior Approval Unit makes the final determination.

Who is eligible for PCA Services?

To be eligible for PCA Services under this program, the person with a disability must meet the following criteria:

- Have a permanent or chronic disability
- Receive benefits from MassHealth
- Be cared for in the home that is considered a permanent, not a temporary living arrangement
- Require physical assistance with two or more of the following ADLs:
 - Mobility, including transfers
 - Bathing or grooming
 - Dressing
 - Toileting
 - Eating or feeding
 - Assisting with medications or other health-related needs
 - Assisting with passive range of motion exercises, in accordance with **130 CMR 422.403 and 422.210**
- Have the PCA services prescribed by a physician

What steps does it take to begin using PCA Services?

- Intake/Assessment
- Orientation training sessions provided by a Skills Trainer
- RN and OT evaluation
- Application and PCA evaluation sent to the PCP for review and signature
- Approval of application and PCA evaluation received back from the PCP
- Application and PCA evaluation sent to MassHealth
- Approval of application received back from MassHealth
- CLW notifies consumer of approval by MassHealth
- Consumer initiates PCA hiring practices

Approvals and Denials

- Notice of Approval

If MassHealth approves a request for PCA services, they will send you and the personal care management agency written notice of the approval. This will include information on the number of hours authorized as well as the effective date of the authorization.
- IMPORTANT

Once authorization is approved and you choose PCA services, you are no longer eligible for homemaker or chore services. Skilled nursing services from a VNA are still allowed. You may not normally receive both Home Health Aide and PCA services, however in some circumstances MassHealth has allowed this. You are responsible for notifying any other service providers when PCA services are approved.
- Notice of Denial and Right of Appeal

If MassHealth denies a request for personal care service or approves less time than the PCM provider agency requested, they will notify both you and the personal care management agency. The notice will give the reason for the denial or modification and will inform you of the right to appeal and the appeal procedure. To appeal a denial or modification, you must request a fair hearing from MassHealth.

The request for a fair hearing must be made in writing within 30 days after the date of the notice of denial or modification. The Board of Hearings will conduct the hearing in accordance with 106 CMR 343.000.

- Re-evaluations

PCA Prior Authorizations (PA) are usually good for one year. Before your Prior Authorization expires, a registered nurse or licensed practical nurse will contact you to schedule a re-evaluation.

- Adjustments

If your needs change during the year, it is possible to request a change in the PCA approval. This might be necessary if, for example, you move out of the family home or your disability progresses. In order to request an adjustment in hours, you should contact your Skills Trainer and explain the circumstances. The PCM provider may require medical documentation of the change and will then submit a request to MassHealth for the additional time. As with routine evaluations, MassHealth may approve, modify or deny the request for a change.

- **IF YOU ARE ADMITTED TO THE HOSPITAL OR A REHABILITATION FACILITY, YOU CANNOT BILL FOR PCA SERVICES DURING YOUR ADMISSION.**

PCA time can only be billed on the day you are admitted and on the day that you return home. It is the responsibility of hospital staff to provide your personal care while you are in the hospital or rehabilitation.

How Can CLW Help Consumers Learn to Use PCA Services?

A Skills Trainer meets with consumers and conducts Program Orientation and Training. This helps consumers to assess their disability and the activities with which they need assistance. Consumers learn how to interview, hire, train and evaluate PCAs, direct and schedule PCAs and complete PCA activity sheets.

C: PERSONAL CARE ATTENDANT SERVICE FOR CONSUMERS NEEDING SURROGATES OR ADMINISTRATIVE PROXY

In October 1988, the Commonwealth of Massachusetts extended eligibility requirements for PCA services to individuals with a disability that prevents them from independently managing their own PCA program. In keeping with this, CLW revised its policies to allow for people to obtain PCA services through the use of a Surrogate. A Surrogate can be a consumer's legal guardian, a family member or any other person identified in the Personal Care Service Agreement as being willing and able to assume responsibility for tasks the consumer is unable to perform.

In January 2020, the Commonwealth of Massachusetts made allowance for a consumer to appoint an Administrative Proxy who can perform administrative functions the consumer is unwilling or unable to perform. A consumer may be assessed to require or choose to appoint an Administrative Proxy to perform administrative tasks, as applicable, on behalf of the Member/Consumer.

A member's Administrative Proxy cannot also be the PCA or an employee or a contractor of either the member's fiscal intermediary or the member's PCM agency. The Administrative Proxy must live in proximity to the member and be readily available to perform the tasks described in the service agreement. A member may not designate an Administrative Proxy if the member has a Surrogate.

A Surrogate or Administrative Proxy must demonstrate a strong personal commitment to the consumer, receive no monetary compensation for this service and cannot be the consumer's PCA or an employee or contractor of the fiscal intermediary or personal care management agency. A Surrogate must be present with the consumer to complete Orientation Training, RN & OT evaluations and RN or LPN re-evaluations, Quarterly and Annual Reviews and be capable of PCA management in the four areas of functional skills:

- PCA training
- PCA management
- Personal health care management
- Emergency management

D: TROUBLE-SHOOTING

Consumer/Surrogate/Administrative Proxy (employer) should call their FI if you:

- Need more activity sheets and other related forms.
- Are having paycheck problems.
- Have problems filling out employer/employee forms.
- Your PCA suggests you contact your FI.

Note: PCAs should never contact the FI or PCM agency. They should always have their employer (consumer/surrogate) contact the FI or PCM agency.

Consumer/Surrogate/Administrative Proxy (employer) should call their PCM agency if you:

- Need face-to-face skills instruction.
- Have questions about hiring, firing, training or scheduling PCAs.
- Need help in finding or recruiting PCAs.
- Need to request an overtime approval (temporary, long-term, emergency)
- Have Prior Approval (PCA evaluation or re-evaluation) questions.
- Have MassHealth eligibility questions (i.e. spend-down, ineligibility, etc.)
- Have changed your primary care physician or managed care vendor.
- Have been advised by your FI to contact your PCM agency.
- Feel that the FI cannot answer your program question.
- Have received a letter that you don't understand (i.e. Prior Authorization (PA) letter, overbilling, overtime non-compliance, PCA orientation, etc)

PCAs should contact their employer (Consumer/Surrogate/Administrative Proxy) if:

- They have any work or form related question.
- They have any paycheck or employee questions.
- They need to adjust their regular schedule.
- They are working over 50 hours per week and require an overtime approval.



CENTER FOR LIVING & WORKING, INC.

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Website: www.centerlw.org

COMPLAINT AND GRIEVANCE POLICY

We at the Center for Living & Working, Inc. (CLW) strive to provide you with quality services. However, there may be times when you (or your representative) disagree with a decision made by CLW staff or you believe services were not provided in a professional manner. For example: you are not satisfied with the services provided by CLW; or, if you are receiving PCA services, you disagree with the PCA Evaluation conducted by the nurse, or with the Service Agreement or Consumer Assessment conducted by your Skills Trainer. You (or your representative) have the right to file a complaint or grievance with CLW if you are dissatisfied with the services we provide.

HOW TO FILE A COMPLAINT OR GRIEVANCE

Should you be dissatisfied with services provided by CLW staff, first contact your CLW staff member by calling CLW at **508-798-0350**. We will make every attempt to resolve your complaint at the time of this initial contact.

If your complaint cannot be resolved at the time of initial contact, you may file a grievance with CLW. Your grievance must be filed in writing and sent to the appropriate **Department Manager** at the above address within 30 calendar days of your initial complaint. CLW will forward written acknowledgment of your grievance request to you within three (3) business days of its receipt. The Department Manager may contact you for further information. The Manager will review all information pertaining to your grievance and send you written notice of their decision within ten (10) business days of receipt of your grievance. If you agree with the Manager's decision, no further action will be needed on your part. If you disagree with the Manager's decision, you have the right to request your case be heard by CLW's **Associate Executive Director of Programs and Services**.

Should you decide to request your case be heard by the Associate Executive Director your request must be in writing and sent to the Associate Executive Director of Programs and Services at the above address within ten (10) business days of receipt of the Manager's decision. The Associate Executive Director will forward written acknowledgment of your grievance request to you within three (3) business days of its receipt, and may contact you for further information. The Associate Executive Director will review all information pertaining to your grievance and send you written notice of her decision within ten (10) business days of receipt of your request. If you agree with the Associate Executive Director's decision, no further action will be needed on your part. If you disagree with the Associate Executive Director's decision, you have the right to request an **Administrative Hearing** with CLW's **Chief Executive Officer**.

HOW TO REQUEST AN ADMINISTRATIVE HEARING

Should you decide to request an Administrative Hearing, the request must be made in writing and sent to CLW's **Chief Executive Officer** at the above address within ten (10) business days of receipt of the Associate Executive Director's decision. You must also include any requests for special accommodations you need during the hearing, and inform CLW if you wish to have a representative at the hearing and, if so, the name of the person. CLW will send you a letter acknowledging receipt of your request for an Administrative Hearing within five (5) business days of receipt of your request. The letter will include the time and location for the hearing, and confirm any special accommodations you have requested. The Chief Executive Officer may request other CLW staff with knowledge of your grievance to attend the administrative hearing.

The Chief Executive Officer will forward a written decision to you explaining the issue(s) involved and resolution of each within ten (10) business days of the hearing.

Please note that the decision of the Chief Executive Officer is CLW's final decision on the matter.

Note: *If you have MassHealth PCA services, this Complaint and Grievance Policy pertains only to decisions made by CLW PCM staff related to services provided by CLW, and does not pertain to a Consumer's appeal rights under MassHealth. Your Skills Trainer can provide you with more information on your appeal rights under MassHealth.*

CLW COMPLAINT AND GRIEVANCE POLICY
SIGNATURE PAGE

I acknowledge that I have been informed of CLW's Complaint and Grievance Policy, and have received a copy of said policy.

Consumer/Legal Guardian Signature

Date

Surrogate Signature (if applicable)

Date

CLW Staff Member Signature

Date

REPORTING ABUSE AND NEGLECT

As a provider of health and human services, staff from the Center for Living & Working, Inc. are required by state and federal law to report if they suspect you are being abused or neglected. If you believe you are being abused or neglected, you also have the right to report the abuse or neglect yourself. Your CLW staff member is available to assist you if needed.

WHAT IS ABUSE AND NEGLECT?

Abuse and neglect can happen in many different ways. For example:

- Physical abuse, which refers to the use of physical force against someone in a way that injures or causes pain to that person;
- Sexual abuse, which occurs when someone is forced to engage in unwanted, unsafe, or degrading sexual activity or exploitation without their express permission or knowledge;
- Financial abuse, which is the illegal or improper use of another person's funds, property, or assets without their express permission or knowledge;
- Emotional abuse can occur when someone is attempting to control another person through threatening, humiliating, or intimidating actions; and
- Neglect, which can occur when someone responsible for your care and well-being fails to provide for your basic daily living needs, resulting in, or placing you at risk of, serious physical or emotional injury.

PROTECTING YOURSELF FROM ABUSE/NEGLECT

There are some steps you can take to protect yourself from experiencing abuse or neglect:

- **PLAN AHEAD**—Talk with family, friends, and professionals that you trust and plan for your future. If you need help with finances, only allow someone you trust to help you manage your finances.
- **BE CAUTIOUS**—unfortunately there are some people who target seniors or people with disabilities and will abuse or take advantage of them. Ensure the people you hire to be your PCAs have been properly screened with criminal background checks completed.
- **STAY CONNECTED**—Keep in touch regularly with others, isolation can make you vulnerable to abuse.
- **REPORT**—Report any suspicion of abuse or neglect by calling one of the numbers below. Don't be afraid to call---you have the right to be safe!!!

If you are ages 18-59:

Disabled Persons
Protection Commission
(DPPC)

1-800-426-9009

1-888-822-0350
(TTY)

If you are 60 or older:

Executive Office of Elder
Affairs (EOEA)

1-800-922-2275

Children ages 0-18:

Department of Children
and Families (DCF)

1-800-792-5200

If you reside in a nursing
home:

Department of Public Health

1-800-462-5540

E: HELPFUL NUMBERS

Here are some helpful numbers that a Consumer/Surrogate/Administrative Proxy (employer) can call if needed:

- The Department of Industrial Accidents (617-727-4900) if you have any accident related questions.
- The Disability Law Center (800-872-9992) if you have any legal questions relating to disabilities.
- The IRS (800-829-1040) if you have any federal tax questions.
- The Massachusetts Department of Revenue (800-392-6089) if you have any state tax questions.
- The Massachusetts Attorney General's Office – Fair Labor Hotline (617-727-3465) if you have any labor questions.
- The Massachusetts Division of Employment & Training (617-727-6560) if you have any labor or unemployment issues.
- The Disabled Persons Protection Commission (800-426-9009) if you feel you have been abused by a PCA.
- The Department of Children and Families (800-792-5200) if you feel that a child (under 18) is being abused or neglected.
- The Executive Office of Elder Affairs (800-922-2275) if you feel that an elder (age 60+) is being abused or neglected.

Section II: PCA Training

Section II: PCA Training

A. FUNCTIONS OF PERSONAL CARE ATTENDANTS

Personal Care Attendants provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living as described in 130 CMR 422.410.

Activities of Daily Living include the following:

- Mobility - physically assisting a member who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment.
- Assistance with medications or other health related needs - physically assisting a member to take medications prescribed by a physician that otherwise would be self-administered.
- Bathing or grooming - physically assisting a member with basic care such as bathing, personal hygiene, and grooming skills.
- Dressing - physically assisting a member to dress and/or undress.
- Range of motion exercises - physically assisting a member to perform range of motion exercises.
- Eating - physically assisting a member to eat. This can include assistance with tube feeding and special nutritional and dietary needs in some situations.
- Toileting - physically assisting a member with bowel and bladder needs.

Instrumental Activities of Daily Living include the following:

- Household services - assisting with household management tasks that are incidental to the care of the member, including laundry, shopping and housekeeping, meal preparation and clean-up.
- Special needs - assisting the member with the care and maintenance of wheelchair and adaptive devices, completing the paperwork required for receiving PCA services, and other special needs approved by the Division as being incidental to the care of the member.

B. PERSONAL CARE ASSISTANCE GUIDE – WORKSHEET FOR ADLs

Another way to help you figure out your ADL needs are to look at each of the following criteria, decide if you do this activity independently, when you do it, and how long it takes.

Activity	Independently	Dependently	Needs Assistance
<u>ADL's</u>			
Transfers			
Assistance with medications			
Bathing - tub			
Showering			
Bed Bath			
Washing hair			
Shaving			
Brushing teeth			
Hair care			
Applying Deodorant			
Manicure			
Pedicure			
Skin care			
Dressing			
Undressing			
Bladder care			
Bowel care			
Menstrual care			
Eating/Feeding			

C. SCHEDULING OF PCA'S BASED ON YOUR NEEDS

Your PCA evaluation will be based on 24 hours per day, 7 days per week. Your PCAs should meet your needs throughout the day. If you schedule your PCAs in block time (i.e., 9 a.m. - 2 p.m.) you will not be able to meet your needs throughout the day. If all your hours are used during the day, who will help you get into bed or make your dinner?

Use the chart below to outline your daily routine and begin to plan a possible schedule.

Activity	Frequency	Time of day
Mobility/transfers		
Medication assistance		
Bathing		
Grooming		
Dressing		
Undressing		
Range of Motion		
Eating/feeding		
Bladder care		
Bowel care		
Other needs:		
Meal Preparation		
Laundry		
Shopping		
Housekeeping		
Wheelchair maintenance		
FI paperwork		
Other		

Section III: PCA Management

Section III: PCA Management

This component includes a general overview of how to advertise for PCAs, including places to advertise, the PCA contract, activities the PCA will perform and business management record keeping. These skills will be explored in greater depth and reviewed between the consumer and the Skills Trainer after the evaluation is approved.

A: HIRING PROCESS

Before you begin the hiring process, it is important that you consider the following:

- The duties and responsibilities of the PCA in relationship to your individual needs. (Refer back to “Activities of Daily Living” and “Worksheet for ADLs”).
- The number of PCAs that you require and whether you want full-time or part-time attendants.
- The schedule of days and hours that you require PCAs to assist you.
Remember that PCAs can NOT work more than 50 hours per week unless you have an Overtime Approval from Mass Health.

Advertising

Once you determine the above, then you are prepared to begin to advertise for the position.

- You may seek help through both formal and informal resources. Talk with others such as those listed below who may know someone looking for PCA work.
 - Massachusetts PCA Directory website www.masspcadirectory.org
 - Check your local paper or call the Unemployment Office (DET)
 - Friends
 - Neighbors
 - Family (Certain family members cannot be your PCA)
 - Medical personnel
 - Other PCA's
 - Other people with disabilities

- If you decide to place an advertisement, where is the best place it will get exposure?
- Your local newspaper
 - Massachusetts PCA Directory website www.masspcadirectory.org
 - A college newsletter or bulletin board
 - A college student employment bureau
 - Church bulletins
 - Supermarket or laundry bulletin boards
 - Vocational rehabilitation agencies
 - The Division of Employment and Training

The advertisement should include the general responsibilities for the position, the hours and whether experience is required. Due to the privacy aspects of the position, you may wish to consider whether you want someone of the same gender providing the services for you. This is only relevant if the services you are seeking include privacy issues. Your advertisement must be neutral regarding age, race, national origin, handicap status, sexual preference and religion. Salary need not be included.

You may want to consider whether you want the applicant to respond to the ad by phone, mail, resume, etc.

Steps to Placing a PCA Job Listing With Massachusetts Employment Service Offices

Locate the office nearest your home on the following page. Call the telephone number and tell whomever answers that you want to list a job opening.

The job order taker will ask you a series of questions about the position. Provide as much detail as possible, particularly with regard to days and hours of employment. If the schedule will allow for some flexibility, mention that. However, be sure to specify any days and times when it is essential for your PCA to be on duty. Be sure to indicate how you want the response to be made, e.g. telephone, forward resume, etc.

Employment Service offices will refer candidates that are interested in the position and have indicated to them that they meet the minimum qualifications that you have specified, e.g. level of experience, education, etc. You will be responsible for ascertaining the validity of the candidates' credentials and for checking references.

There is no charge for listing a job opening with any Massachusetts Employment Service office.

Personal Care Attendant Workforce Council

The mission of the PCA Quality Home Care Workforce Council is to: insure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the work force of personal care attendants (M.G.L. c.118G § 29). As part of this mission the Council negotiated the first ever labor contract for PCAs. There has been a good deal of rumor about what unionizing PCAs will mean for consumers. Listed below are specific facts about the contract. For more information please visit the PCA Workforce Council Website at www.masspcadirectory.org

The new contract will raise the wages of PCAs as follows:

Effective July 1, 2018, the PCA wage rate shall be \$15.00 per hour.

Effective July 1, 2019, the PCA wage rate shall be \$15.40 per hour.

This contract preserves a consumer's right to hire, supervise and fire PCAs at their discretion. The grievance procedures in the contract do not apply to consumers. Please note that, from time to time consumers may receive union materials in the mail. These materials should be given to your PCA.

The Council does not have the staff to answer individual questions by telephone. You can e-mail the Council at pcacouncil@state.ma.us

Massachusetts PCA Workforce Council's PCA Directory

Helps individuals and families in Massachusetts to find personal assistants (PCAs). The Massachusetts PCA directory, working with Rewarding Work Resources, provides a comprehensive and current list of people in Massachusetts who are ready to provide personal care assistant (PCA) services in your home.

- If you receive PCA services from MassHealth, including CommonHealth, *or*
- If you do not receive PCA services from MassHealth, *or*
- If you want a job as a PCA or direct care worker

You can get names, contact information, and availability of PCAs for full- or part-time work, review their experience, and learn if they are available to work mornings, days, evenings, or weekends. Please visit: www.masspcadirectory.org website.

You can also place an ad for Free for a PCA on the Rewarding Work (findpca) website. As with other ads you should be specific about the general responsibilities for the position, the hours and whether experience is required. PCAs will be able to respond to your ad but will not be given your personal information. You will receive an email response from the PCA and then you decide who to contact. Please see flyer on next page.

B: INTERVIEWING

Once you have decided to conduct interviews for the PCA position, it is important that you carefully consider the questions that you pose during the interview. As previously mentioned, it is important to have a prepared list of duties and responsibilities for the position. This job description should form the basis of your interviewing. (See Sample Job Description) You are allowed to ask questions of the candidate as to whether or not they can perform the duties and responsibilities you have identified for the position. In fact, a copy of the job description may be provided to the candidate during the interview itself. This allows you and the candidate to focus on the responsibilities for the position.

You should avoid questions that do not focus on the duties of the position
Such as:

- The candidate's age (unless they are under 18 years of age)
- National origin
- Race
- Handicap
- Sexual preference
- Religion
- If the candidate ever experienced an injury on the job
- If the candidate has children or
- child care arrangements

If your individual needs require transportation, you may inquire as to the driving record of the candidate. You may request that the candidate provide you with a driving record history from the Registry of Motor Vehicles. If you are interested in hiring the candidate, a copy of their registration and insurance may also be appropriate.

As part of the interview, you may determine whether the candidate's schedule of available hours coincides with your individual needs.

The salary for the position and any benefits should be discussed during the interview. Personal requirements regarding smoking, appearance, etc. should also be made known during the interview.

A sample job application has been enclosed for your consideration. The application simply requests the candidate's name, address, telephone number, age (if under 18), employment history, relevant skills and references. In reviewing the employment history, it is especially important to review the continuity of employment, the reasons for any break in employment and the stated reasons for leaving their last three positions. When verifying references, compare the answers provided in the application to the information provided in the reference. Any discrepancy is a potential cause for concern. References should be verified before employment begins. References may be verified by phone or in writing. The candidate should provide written permission when seeking a reference from a previous employer. A sample reference form has been enclosed. Many employers only provide references that indicate name, dates of employment and position held. Do not view this type of reference negatively. However, the more information you can obtain, the better prepared you will be to make an informed decision.

SAMPLE- PCA Job Application

PCA JOB APPLICATION

NAME: _____
First Middle Last

ADDRESS: _____
Street
City/town State Zip Code

PHONE: (____)____-____

SOCIAL SECURITY NUMBER:----- **AGE** (if under 18): ____

APPLICATION DATE ____ / ____ / ____

EMPLOYMENT HISTORY:

Date:

Mo/Year:

Name/Address of Employer:

Telephone:

Salary:

Position:

Reason for Leaving:

Please describe the specific skills and abilities you possess which relate to the job in which you are applying.

REFERENCES: Please list three people not related to you as references.

Name

Address

Business

Telephone Number

Years Acquainted

1.

2.

3.

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein. I further authorize the references listed to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise. I hereby release all parties from liability for any damage that may result from furnishing it to you.

I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time without prior notice.

Applicant

Date: _____

Signature: _____

SAMPLE- Reference Form

REFERENCE FORM

_____ has applied for a position as a Personal Care Attendant. Please fill out this form and return it to me in the enclosed self-addressed, stamped envelope as soon as possible. Thank you for your help in this matter.

Dates	Position	Social Security #		
	Good	Fair	Poor	
Punctuality	_____	_____	_____	
Dependability	_____	_____	_____	
Quality of Work	_____	_____	_____	
Ability to Take Direction	_____	_____	_____	
Honesty	_____	_____	_____	

Would you rehire? _____

Other comments: _____

_____ has authorized the release of this
(PCA applicant name)
Information to PCA Applicant _____ as
indicated by the signature below. (Consumer name)

Signature of PCA applicant _____ Date _____

Personal Care Attendant Interview Questions

1. What is your understanding of a PCA's job?
2. Why do you want this job?
3. Have you done this type of work before? Where? For whom?
4. Could you explain how you did tasks for previous consumers?
5. What cooking experience do you have?
6. What form of transportation do you have?
7. Would you be able to provide transportation?
8. How many hours do you wish to work per week?
9. What days and hours are you available? When would you be able to start?
10. This job pays \$_____per hour. I submit all PCA hours to Stavros every 2 weeks. A check will be mailed to me to distribute to my PCAs. Would this arrangement be satisfactory to you?
11. It will be necessary to furnish identification and a Social Security number. Is this a problem?
12. This job will entail ... (list a complete schedule of activities and responsibilities).
13. You would be working for me directly. There is no connection between CLW or Stavros and you. I am the employer and make all decisions concerning my personal care needs. Can you take direction from me?
14. Do you have references? I would like to have three references.
15. Could you get here in bad weather?
16. If you could not work when scheduled, what would you do to help me fill in those hours? Would you be willing to call another PCA?
17. If you have been drinking or taking drugs either while working or before coming to work, I will fire you immediately. Do you understand this?
18. Would you be willing to give two weeks' notice if you decide to leave this job?
19. Do you have any questions?

SAMPLE- PCA Job Description

JOB DESCRIPTION

EQUIPMENT: Electric wheelchair with mold, adaptive eating utensils, bath sling chair, hospital bed and lift.

LIVING ARRANGEMENT: Alone in apartment.

NEEDS ASSISTANCE WITH:

BATHING: Transfer in and out of shower/tub. Assistance with washing. Assistance with drying body and hair. Assistance with shaving legs and underarms before bath. Bed bath on non-shower days.

DRESSING: Total assistance with dressing. Done in bed.

ORAL HYGIENE: Total assistance with brushing and flossing twice a day.

BLADDER CARE: Assistance on and off bedpan. Total assistance with clean up.

BOWEL CARE: Assistance on and off bedpan. Total assistance with clean up. Suppositories when needed.

TRANSFERRING: Cradle lift from chair to bed, chair to tub and vice versa.

EXERCISE: Range of motion in morning and in evening per instruction. Done in bed.

MEAL PREPARATION: Total assistance with general clean up, vacuuming, mopping floors, making bed, dishes, removing trash, etc.

LAUNDRY: Total assistance. Twice per week.

GROCERY SHOPPING: Assistance with list. Accompany to store weekly.

RECORD KEEPING: Assistance with writing records such as banking, PCA records and other correspondence per instruction.

MEDICATIONS: Assistance with giving medications. (Always in front of me)

EQUIPMENT MAINTENANCE: Wash wheelchair and wipe out mold once a week. Check batteries for water and tire pressure weekly. Fill as needed. Maintain other equipment as directed.

Employee Name

Date

SAMPLE- PCA Job Description

JOB DESCRIPTION

Title: Personal Care Attendant

Responsible: (consumer's name)

Duties may include providing assistance with:

1. Personal Care: Activities of Daily Living (ADLs), Transfers in and out of wheelchair (includes lifting), dressing and undressing, bathing, grooming, range of motion exercises, toileting needs.
2. Meal preparation, feeding, and clean up.
3. Housekeeping, cleaning and laundry.
4. Shopping for food and other necessities.
5. Nighttime care, such as repositioning and assisting with toileting.
6. Miscellaneous: Record keeping, banking, billing for PCA services, etc.
7. Additional duties as required by the consumer.

Employee Name

Date

BACKGROUND CHECKS ON YOUR PCA

Before your PCA can be on your payroll, they need to be checked against the federal government's Office of Inspector General's Exclusion List. This list has the names of individuals or entities that cannot provide services paid by Medicaid or Medicare or any other federal agency. We recommend you contact Stavros Fiscal Intermediary directly to check the eligibility of your PCA's **before** they start working for you. You can check their eligibility yourself by going to the web site at www.oig.hhs.gov. You can also access this web page through CLW www.centerlw.org and Stavros Fiscal Intermediary www.stavros.org.

Warning: If you hire a PCA and their name is on the exclusion list but you submit a time sheet for payment, Stavros will not process their payroll, therefore you will be responsible for payment of hours your PCA has worked.

CRIMINAL OFFENDER RECORD INFORMATION (CORI) AND SEX OFFENDER REGISTRY INFORMATION (SORI)

CLW strongly encourages all PCA Consumers conduct background information checks through a Criminal Offender Record Information (CORI) and a Sex Offender Registry Information (SORI). A CORI consists of records and data in any communicable form compiled by a Massachusetts criminal justice agency about an identifiable individual that relate to: an arrest, a pre-trial proceeding, other judicial proceedings, sentencing, incarceration, and release. CORI checks do NOT include restraining orders to prevent abuse or harassment, child abuse or neglect reports or juvenile history, except for charges on which a juvenile was adjudicated as an adult.

A Massachusetts CORI will only report if your PCA has ever been charged with a crime in a Massachusetts court and will NOT include charges in other states. If a prospective PCA lives, or has lived in another state you may want to consider checking the CORI for that state. You can find more information on requesting out of state CORI checks at <http://www.mass.gov/eopss/crime-prev-personal-sfty/bkgd-check/cori/request-rec/requesting-out-of-state-criminal-records.html>

Your Skills Trainer is available to answer any questions you have on CORI and

SORI. Your Skills Trainer will assist you in completing the CORI and SORI forms and instruct you on how to submit these requests free of charge. You may access the "On behalf of/Home Health Aide CORI Request Form" here <http://www.mass.gov/eopss/docs/chsb/home-health-aide-request-form.pdf> which will allow you to request the CORI free of charge. The form must be notarized by having the PCA sign the form in the presence of a Notary. In addition, a blank CORI form application is on the following pages. You may also find more information at www.mass.gov/cjis.

SORI requests are made to the Sex Offender Registry Board

Any member of the public who is at least 18 years of age or older may request sex offender information. The Board will only disseminate information on offenders who have been finally classified as a Level 2 (moderate risk) or Level 3 (high risk) offender. The law prohibits the dissemination of information unless and until the offender is finally classified as a Level 2 or a Level 3 offender. The law strictly prohibits the dissemination of information on Level 1 (low risk) offenders. You can find the form to request Sex Offender Information here; <http://www.mass.gov/eopss/docs/sorb/request-tosorb.pdf>. The information will be provided free of charge.



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606
MASS.GOV/CJIS



On Behalf Of/Home Health Aide Criminal Offender Record Information (CORI) Request Form

Use this form for requesting CORI under the provisions of M.G.L. c. 6, § 172. This form may be submitted by an Elderly or Disabled person who seeks to screen a prospective home health aide. Legal guardians or individuals who have power of attorney to make decisions on behalf of an elderly or disabled person may submit this form on behalf of that person. Mail requests to the address provided above, **ATTN: CORI Unit**.

Requestor Details

Complete this section with your information. Items marked with an asterisk (*) MUST be completed.

*First Name: _____ Middle Initial: _____
*Last Name: _____ Suffix (Jr., Sr., etc): _____
* Date of Birth (MM/DD/YYYY): _____ Last **SIX** digits of Social Security Number: _____ -- _____
* Phone Number: _____ Email Address: _____
*Street Address: _____
*Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

On Behalf Of

If different from above, complete this section with the details of the person on whose behalf you are requesting CORI.

*First Name: _____ Middle Initial: _____
*Last Name: _____ Suffix (Jr., Sr., etc): _____
*Date of Birth (MM/DD/YYYY): _____ Last **SIX** digits of Social Security Number: _____ -- _____
*Phone Number: _____ Email Address: _____
*Street Address: _____
*Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

Subject Details

Complete this section with the information of the person whose CORI you are requesting.

*First Name: _____ Middle Initial: _____
*Last Name: _____ Suffix (Jr., Sr., etc): _____
Former Last Name 1: _____
Former Last Name 2: _____
Former Last Name 3: _____
Former Last Name 4: _____
*Date of Birth (MM/DD/YYYY): _____ Last **SIX** digits of Social Security Number: _____ -- _____
*Father's Full Name: _____

*Mother's Full Name: _____

Applicant's Agreement of Understanding

I understand that elderly or disabled persons may access all available CORI, including convictions, non-convictions, and pending Massachusetts criminal history, for the purpose of screening home health aides or other such positions providing care or services to an elderly or disabled person in his or her home. As an applicant for such a position, I understand that a criminal record check will be performed on me and that the results will not be further disseminated by the requesting individual.

Signature of Applicant

Date

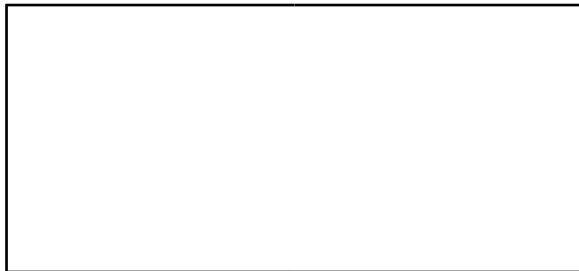
Authentication of Signature

Please note that ALL fields in this section must be completed by the Notary Public.

On this _____ day of _____, 20_, before me, the undersigned Notary Public, personally appeared _____ (name of CORI subject) and proved to me through satisfactory evidence of identification, which was _____ (Ex: Driver's license, passport, etc.), to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he)(she) signed it voluntarily for its stated purpose.

Signature of Notary Public (Notary stamp or seal is also required)

Date my Commission expires



Terms and Conditions

By submitting a request for CORI using this form, the Requestor agrees to be bound by these terms and conditions and any and all other guidelines, disclaimers, rules, and privacy statements within this agreement, collectively referred to as "Terms and Conditions." All Terms and Conditions contained herein apply only to obtaining information from the DCJIS.

1. As referenced in these terms and conditions, the terms below shall have the following meanings:
 - a. CRA: Consumer Reporting Agency
 - b. CRRB: The Criminal Record Review Board
 - c. CORI: Criminal Offender Record Information
 - d. DCJIS: The Massachusetts Department of Criminal Justice Information Services

- e. iCORI service: The internet-based service used to request and obtain CORI and self-audits.
 - f. Requestor: A registered user of the iCORI service and any additional authorized users for the requestor's account. Requestor, as used in these terms, also includes Consumer Reporting Agency requestors. Requestor, as used in these terms, also includes any individual who requests or obtains CORI or a self-audit report from DCJIS using a paper form.
2. Obtaining CORI from DCJIS by using this form is subject to Massachusetts General Law and to Federal law, including, but not limited to, M.G.L. c.6, §§ 167-178B (the CORI Law), M.G.L. c. 66, § 10 (the Public Records Law), M.G.L. c. 266, § 120F (Unauthorized use of a computer), and any current or future laws applicable to the use of computer systems or personal information. The penalties for violations of these laws include both civil and criminal penalties.
 3. A requestor may only request the level of CORI access authorized by statute or the DCJIS for the type of request being submitted. A requestor who submits a CORI request using an access level higher than that authorized for the type of request being submitted will be in violation of the CORI law and DCJIS regulations and may be subject to both civil and criminal penalties.
 4. An individual or entity who knowingly requests, obtains, or attempts to obtain CORI or a self-audit from the DCJIS under false pretenses, or who knowingly communicates, or attempts to communicate, CORI to any individual or entity except in accordance with the CORI law and DCJIS regulations, or who knowingly falsifies CORI or any records relating thereto, or who requests or requires a person to provide a copy of his or her CORI except as authorized pursuant to M.G.L. c. 6, § 172, shall, for each offense, be punished by imprisonment in a jail or house of correction for not more than one year or by a fine of not more than \$5,000.00. In the case of an entity that is not a natural person, the amount of the fine may not be more than \$50,000.00. In the case of such a violation involving juvenile delinquency records, an individual or entity shall, for each offense, be punished by imprisonment in a jail or house of correction for not more than one year or by a fine of not more than \$7,500.00. In the case of an entity that is not a natural person, the amount of the fine may not be more than \$75,000.00.
 5. Neither the DCJIS nor the CRRB shall be liable in any civil or criminal action due to any CORI or self-audit report that is disseminated by the DCJIS or the CRRB, including any information that is false, inaccurate, or incorrect, because it was erroneously entered by the court or the Office of the Commissioner of Probation.

6. CORI results are based on an exact match of the information provided by the requestor to information as it appears in the CORI database. Requestors are responsible for providing accurate information for the subject requested. In addition, it is the requestor's responsibility to compare the CORI or self-audit results received from the iCORI service to the subject's personal identifying information to ensure that the results match this information. The DCJIS is not liable for any errors or omissions in the CORI results based on a requestor's submission of inaccurate, incorrect, or incomplete subject information. Furthermore, NO REFUNDS of CORI fees will be provided because of data entry errors or other errors or omissions made by the requestor.
7. Each requestor who submits 5 or more background checks annually must have a written CORI policy. Each requestor is responsible for adopting its own CORI policy. The DCJIS publishes a model CORI policy on its website that may be adopted for use by requestors. If this requirement applies to a requestor, the requestor agrees that at the time of submission of any CORI request, it has adopted a CORI policy.
8. The requestor agrees that he/she has reviewed and understands all training materials regarding the CORI process and CORI requirements available from the DCJIS. Requestors are solely responsible for reviewing and understanding the training materials provided by the DCJIS.
9. Requestors who seek to receive the standard or required level of access to CORI for employment, housing, licensing, or volunteer purposes must ensure that the following are completed prior to submitting a CORI request:
 - a. Completion of a CORI Acknowledgement Form for each subject to be checked;
 - b. Verification of the identity of the subject using an acceptable form of government issue identification;
 - c. Obtaining the subject's signature on the CORI Acknowledgement Form;
 - d. Signing and dating the CORI Acknowledgement Form certifying that the subject was properly identified; and
 - e. Confirming that the requestor is in compliance with all applicable laws and regulations.
10. All requestors, including those that request CORI through a CRA, must comply with 803 C.M.R. 2.00 and, if applicable, 803 C.M.R. 5.00. In addition, CRAs are also responsible for ensuring compliance with the Fair Credit Reporting Act and with DCJIS regulation 803 CMR 11.00.
11. A requestor that uses CORI to commit a crime against, or to harass, another individual is subject to the criminal penalties set forth in M.G.L. c. 6, §178 ½, including imprisonment in

a jail or house of correction for not more than one year and a fine of not more than \$5,000.00. The DCJIS and the CRRB disclaim any liability for the improper use or dissemination of information obtained through the iCORI service.

12. Requestors are subject to audit at any time by the DCJIS and may be asked to produce documentation to demonstrate compliance with these provisions and with DCJIS regulations (803 CMR 2.00-11.00 et seq.).
13. No information obtained from the iCORI service or from DCJIS personnel regarding use of the iCORI service shall be construed as legal advice.
14. The DCJIS reserves the right to alter, amend, or discontinue any feature of the iCORI service or the conditions of its use at any time. Any such changes will be announced on the iCORI service and/or the DCJIS website in advance. The user is subject to the terms of use in effect at the time of his/her agreement. The DCJIS and the CRRB shall not be liable for any damages associated with use of this site.
15. These Terms and Conditions are governed by, and construed in accordance with, the laws of the Commonwealth of Massachusetts and the laws of the United States, without giving effect to any principles of conflicts of law. If any provision of these Terms and Conditions is determined to be unlawful, void, or for any reason unenforceable, then that provision shall be considered void. The remaining provisions shall remain valid and enforceable.
16. By submitting a request for CORI to the DCJIS, I affirm that I have read and understand these Terms and Conditions. Further, I acknowledge, agree to, and am bound by, these Terms and Conditions, as well as by M.G.L. c. 6, §§ 167-178B, inclusive, and 803 CMR 2.00-11.00, inclusive.

Personal identifying characteristics:

Sex: _____ Race: _____ Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Other information (e.g. license plate number, parents' names, etc.):

If additional information is needed, please contact the Requestor at the telephone number above.

*******WARNING*******

SEX OFFENDER REGISTRY INFORMATION SHALL NOT BE USED TO COMMIT A CRIME OR TO ENGAGE IN ILLEGAL DISCRIMINATION OR HARASSMENT OF AN OFFENDER. ANY PERSON WHO USES INFORMATION DISCLOSED PURSUANT TO M.G.L. C. 6, §§ 178C – 178Q FOR SUCH PURPOSES SHALL BE PUNISHED BY NOT MORE THAN TWO AND ONE HALF (2 ½) YEARS IN A HOUSE OF CORRECTION OR BY A FINE OF NOT MORE THAN ONE THOUSAND DOLLARS (\$1000.00) OR BOTH (M.G.L. C. 6, § 178N). IN ADDITION, ANY PERSON WHO USES REGISTRY INFORMATION TO THREATEN TO COMMIT A CRIME MAY BE PUNISHED BY A FINE OF NOT MORE THAN ONE HUNDRED DOLLARS (\$100.00) OR BY IMPRISONMENT FOR NOT MORE THAN SIX (6) MONTHS (M.G.L. C. 275, § 4).

SOR Form 4 (12/18)

THE DISABLED PERSONS PROTECTION COMMISSION
300 GRANITE STREET, SUITE 404
BRAINTREE, MA 02184
TO REPORT ABUSE: 1-800-426-9009 V/TTY (24 HOUR HOTLINE)
BUSINESS OFFICE: 617-727-6465 V/TTY

- **OVERVIEW**

The Disabled Persons Protection Commission (DPPC), operating under M.G.L.c.19C, has as its purpose to “investigate and remediate instances of abuse of disabled persons in the commonwealth.” The Commission, similar to the Department of Children & Families for children and the Executive Office for Elder Affairs for elders, acts to protect a particularly vulnerable segment of the population: disabled adults between the ages of 18 and 59 years, who are dependent on another to meet daily living needs, effectively “filling the gap” between the child protection and elder protection systems. The Commission is able, by the terms of its statute, to act independently in investigations and the protection of disabled persons in state care and in private settings, and for the investigation of abuse in those settings.

- **DEFINITIONS**

The DPPC statute is contained in chapter 19C of the General Laws. The statute defines a **disabled person** as a person between the ages of 18 and 59, inclusive, who is mentally retarded or otherwise mentally or physically disabled and as a result of the disability is wholly or partially dependent upon others to meet daily living needs.

Abuse is defined as serious physical or emotional injury, which results from an act or omission.

A **caretaker** of a disabled person is defined as the person or agency responsible for a disabled person’s health and welfare, whether in the same home, a relative’s home, a foster home, or any day or residential setting.

- **REPORTING**

Under the law, the Commission receives reports of suspected abuse of disabled adults. Certain individuals, who, in their professional capacity have regular contact with disabled persons and therefore are more likely to be aware of abuse, are required to report to the Commission. The professions included in the list of those who are so-called mandated reporters are virtually the same as those who are required to report cases of suspected abuse of children and elderly persons—medical

personnel, police officers, probation officers, dentists, teachers, social worker and psychologists, guidance counselors, and employees of private agencies providing services to disabled persons. Additionally, the statute adds to this list employees of the agencies within the Executive Office of Human Services. If any of these individuals fails to make such a report, that person is liable for a fine of up to \$1000. In return for this requirement, however, mandated reporters are immune from any civil or criminal liability as a result of making a report.

All other citizens are encouraged to report to the Commission and are also immune from liability if their report is made in good faith.

The Commission receives reports 24 hours a day through it's Hotline at **1-800-426-9009 V/TTY** and the business office may be reached during regular business hours at **617-727-6465 V/TTY**.

- **INVESTIGATION**

Upon receiving a report, the Commission may investigate itself, or refer the matter to the appropriate state agency for investigation with DPPC monitoring. First the Commission determines the nature of the alleged abusive situation, depending upon the disability of the allegedly abused person and the identity of the caretaker of that person. When a state agency is the caretaker of the disabled person, the referral is made to that agency. The Commission then monitors the investigation. When the caretaker is not a state agency, the case, if referred, is sent to the Department of Developmental Services in the case of alleged victims who are developmentally disabled, to the Department of Mental Health when the person is otherwise mentally disabled, or to the Massachusetts Rehabilitation Commission when the disabled person is physically disabled.

The Commission must also determine the urgency of the situation. When the case is an emergency, the Commission first acts to end the danger, regardless of the identity of the victim. Once that has occurred, the case is referred for investigation, unless the alleged victim is a child or person 60 years of age or older, in which event the matter is referred to the appropriate agency. When the victim is a disabled adult, an emergency report is referred to the proper agency as described above and within 24 hours that agency is required to complete an investigation and evaluation and, if necessary, provide protective services to the disabled person.

When the case is not an emergency the investigation, evaluation, and provision of protective services must be completed within 10 days.

The Commission monitors all investigations and receives investigation

and evaluation reports from the agency.

Additionally, the Commission may conduct a formal investigation which includes a hearing to ascertain the scope of, and remedy for an abusive situation.

When the Commission investigation involves a matter which is also the subject of a law enforcement investigation the Commission may delay or defer its investigation. However, the Commission is *required* in such a situation to monitor the law enforcement investigation.

The statute also provides a criminal penalty for persons who discharge, discipline, threaten, or discriminate against anyone who reports to or provides information regarding abuse of a disabled person to the Commission, or agencies in the Executive Office of Human Services.

- **PROTECTIVE SERVICES**

The Commission insures, in cases where disabled persons have been abused, that the victim receives the necessary services to provide protection. These may include but are not limited to legal services, location of alternative housing, counseling, respite services, and social service case management. The competent disabled adult may, of course, decline services.

The Commission may, in cases where the disabled person does not have the capacity to consent to the provision of protective services, request that a court decide for the person whether protective services should be provided. The court may appoint a guardian *ad litem* for the person or issue other protective orders.

The Disabled Persons Protection Commission is located at 300 Granite Street, Suite 404, Braintree, MA 02184 Please contact the Commission for further information.

C: EMPLOYMENT REQUIREMENTS— THE CONSUMER AS THE EMPLOYER

After you have completed the interviewing process, you are now ready to make an offer of employment to the selected candidate. The offer of employment may be initially communicated orally to the selected candidate, but should be confirmed in writing. When contacting the selected candidate, you should inform them that you have an interest in employing them as your PCA and ask whether they still have an interest in the position. If they continue to express an interest in the position, offer them the position with the stated salary, benefits (if any), start date and hours. If the position is accepted, a written confirmation of employment should be provided to the selected candidate. (See Sample Confirmation of Employment.)

As an employer, you now have certain responsibilities under both state and federal law. All employees are required to complete I-9 forms for immigration purposes. All employees are required to complete W-4 forms for tax purposes. Once these forms are completed, originals should go to the FI. You should save applications, references, immigration and naturalization forms and W-4's for all PCAs. You should also keep a copy of the activity forms you submit and the summary report from each PCA payroll packet. This will give you information of the earnings for each of your PCAs. In addition to these documents, your PCA files should include the start date, the last date of employment and the reason for termination.

The Commonwealth of Massachusetts is an “employee at-will” state. This means that employees are hired at the “will” of the employer. The employer can terminate the employee’s employment at any time for any lawful reason. Conversely, an employee may resign from his/her employer at any time for any reason and without providing any notice. An employer may request an employee provide notice prior to any resignation, but cannot require it. If an employee is hired for a guaranteed period of time or pursuant to an employment contract, the employee will no longer be considered an “employee at-will”. Consequently, all references to any guarantee of employment or promise of employment for a specified period should be avoided. Although an employer can terminate an employee at any time for any lawful reason, employers must make sound and rational decisions when deciding to discipline or terminate an employee. It is unlawful in Massachusetts to discipline or terminate an employee due to their age, race, gender, sexual preference,

national origin, and religion or handicap status. Massachusetts General Laws, Chapter 151B, is the statute that prohibits discrimination in the work place. Additionally, there are other situations where an employee may not be lawfully fired. It would be inappropriate to detail all of those reasons in these guidelines. If you have concerns regarding the performance of your PCA, you should contact an attorney for advice regarding discipline or termination. Once a decision has been made to terminate an employee, it will be important to have the PCA return any items or documents that are the properties of the consumer.

Upon hire, it will be important to provide your PCA with a job description that details the duties and responsibilities of the position. The job description should be signed and dated so both you and your PCA understand the scope of the position. A copy of the signed job description should be maintained in the personnel file. The job description should be reviewed on an annual basis to see if any changes are warranted. In addition to the job description, a list of the specific tasks and duties should be prepared that provides you and the PCA with a daily schedule. An orientation checklist should be prepared for review with your PCA as soon as possible after the PCA has been hired. The orientation checklist will generally describe the location of certain items such as medication, phone numbers (family member, emergency), addresses and other items of importance to you. (See Sample Orientation Checklist.) This checklist should also be signed and dated.

In addition, a list of expectations should be prepared which indicates the requirements for the position. For example, if you require that the PCA will be a non-smoker, one of the expectations will be "I agree that I will not smoke while on the job." You may want to consider, for example, a probationary or trial period for your new employee. Generally, this period may run from 30 to 90 days. (See Sample Expectations.) This list, like the job description, task list and orientation checklist, should be tailored to your individual needs. The list of expectations should also be signed and dated.

MassHealth does not offer vacation time and this should be clearly discussed with a potential employee. Whether you offer benefits to your PCA is an individual decision, and financially your responsibility. If no benefits are offered, this fact should also be communicated to your PCA at the time of interview and hire.

If a consumer is utilizing the services of this program in an out of state residence, many of the regulations and laws will be different as compared to Massachusetts. You should check with the state's agencies and with private counsel to determine your obligations as an employer in any states that you may be visiting. If you travel out of state with your PCA, you should also consider checking the state laws where you will be traveling as it relates to worker's compensation, etc. If your trip requires that your PCA spends more than 40 hours with you in any given week, you should contact the Fair Labor and Business Practices Division of the Attorney General's office (617-727-3465) to determine whether the overtime pay provision of the law will be in effect.

SAMPLE- Confirmation of Employment

CONFIRMATION OF EMPLOYMENT

Date:

Name:

Address:

Dear Ms. /Mrs. /Mr. _____:

I am pleased to confirm that you have accepted the position of Personal Care Attendant for myself. The salary for the position is _____. The benefits for the position are _____. Your start date will be _____. The scheduled hours and days will be as follows: _____.

Upon your first day of employment, you will be expected to sign the job description, task list and expectations of the position. The expectations of the position include, in part, your agreement to maintain confidentiality regarding my personal affairs. Since you are going to be an employee, you must provide a copy of your driver's license and social security card for immigration purposes. A birth certificate or passport may be substituted. You will be asked to complete a W-4 form related to your tax status. Stavros will be the Fiscal Intermediary and will be working with me to provide you with a timely paycheck and appropriate tax withholdings. You will be considered an employee at-will. This does not guarantee you employment for any specified period of time. I look forward to working with you and expect to see you on _____.

If you have any questions, please call me as soon as possible.

Sincerely,

_____, Employer

SAMPLE- Expectations

EXPECTATIONS

I, _____, a Personal Care Attendant for
_____ Agree to the following terms and conditions of
employment:

1. To keep confidential the personal affairs of my employer.
2. To respect the rights and privacy of my employer and/or his/her surrogate.
3. To refrain from smoking on the job.
4. To perform my duties and responsibilities to the best of my ability.
5. To follow directions.
6. To be punctual.
7. To refrain from any consumption of alcoholic beverages during my workday.
8. To refrain from any illegal drug use during my workday.
9. To inform my employer if I am not fully able to perform my duties and responsibilities.
10. To call my employer at least _____ hours in advance if I am unable to report to work.
11. To dress appropriately for the responsibilities of my position.
12. To cooperate with Stavros Fiscal Intermediary, as necessary, as relates to my paycheck, hours of employment and any forms that need to be completed for the benefit of either myself or my employer.
13. To be subject to a Probationary Period of _____ days.
14. To maintain all property that has been provided to me by my employer for

use during my employment in a proper manner, and to return same upon completion of my employment.

I understand that violation of these expectations may result in discipline up to and including termination.

Employee

Date

SAMPLE- Orientation Checklist

ORIENTATION CHECKLIST

The following items have been reviewed with: _____

1. Personnel forms (I-9, W-4, Application)	
2. Job description	
3. Task List	
4. Expectations	
5. Medications	
6. Emergency phone numbers and addresses	
7. Tour of the residence, including operation of equipment and appliances	
8. Motor vehicle registration and insurance	
9. Other	

Employer

Date

Employee

Date

The Top 10 Reasons Why PCAs are fired

1. The Personal Assistant is repeatedly not dependable in arriving at work on schedule, often arriving late or leaving early, or fail to call in advance to notify Consumer/Surrogate of schedule changes.
2. The Personal Assistant is not reasonable, clean, and professional in personal hygiene, language or habits.
3. The Personal Assistant jeopardizes the safety or health of the Consumer by performing poor quality of work.
4. The Personal Assistant proves to be physically, emotionally or psychologically unable to meet the expressed job expectations.
5. The Personal Assistant has been dishonest in their completion of job duties, or in reporting of time worked.
6. The Personal Assistant has an inappropriate attitude towards individuals with disabilities, and is unwilling to be educated to the Consumer/Surrogate's viewpoint.
7. The Personal Assistant lacks respect for the Consumer's confidentiality, belief system or feelings.
8. The Personal Assistant tries to control the Consumer's right to make decisions.
9. The Personal Assistant is not appropriately clear in daily communication with the Consumer/Surrogate.
10. The Personal Assistant simply does not want to continue to perform the duties of the work according to schedule and methods already clearly expressed.

Adapted from:
Home Health Aides...How to Manage the People Who Help You
By, Alfred H. Degraff

Some Reasons Why PCAs Quit

1. The Personal Assistant receives an incomplete list of duties or procedural instructions at point of hire, and become frustrated as unexpected duties are required.
2. The working environment is unpleasant and frustrating because it lacks adequate supplies or is disorganized or unclear.
3. The Personal Assistant is unclear of the pay schedule and/or pay rate, as well as benefits which may come with their job.
4. When more than one Personal Assistant is employed and there is unequal treatment and expectations towards one of them.
5. The Consumer/Surrogate is not appropriately assertive and clear regarding communication relating to job expectations and needs.
6. The Consumer/Surrogate is dishonest regarding time worked or salary owed to Personal Assistant.
7. The Consumer/Surrogate is unreasonable in demanding duties that are inappropriate for the Personal Assistant to perform.
8. The Consumer/Surrogate is intolerant of honest mistakes made by the Personal Assistant, or is inflexible regarding sick time or time off.
9. The Consumer/Surrogate fails to recognize the personal life of the Personal Assistant, assuming that the consumer's unexpected needs are paramount to the needs of the Personal Assistant.

Adapted from:
Home Health Aides...How to Manage the People Who Help You
By, Alfred H. Degraff

Section IV: Personal Health Care Maintenance

Section IV: Personal Health Care Maintenance

A: UNDERSTANDING AND DESCRIBING YOUR MEDICAL CONDITION

In order to properly train your PCA, you need to be able to describe to them the nature of your disability and any problems or susceptibilities to which you may be prone. Use the space below to identify with your Skills Trainer the following:

- Disability:

- How does this affect me?

- Problems I may develop:

- Areas in which I am prone: (UTIs, pneumonia, choking, etc.)

B: UNDERSTANDING AND DESCRIBING YOUR ROUTINES AND TREATMENTS

In order to properly train your PCA, you need to be able to describe to them your routines and treatments which may include such things as dressing changes, nebulizer treatments, range of motion exercises, medication schedule and dosages, nutritional planning, bowel and bladder routine, etc.

- Please use the space below to describe *your* routine and treatments:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on its right side, suggesting it's resting on a surface.

Section V: Emergency Management

Section V: Emergency Management

In this module you will compile a list of emergency contacts (ambulance, doctors, fire department, etc.) and post it in a highly visible place within your home; discuss how to proceed in an emergency; and pinpoint which family members, friends or neighbors to contact in an emergency. These can be outlined with help from “Emergency Medical Procedures” below.

A: HEALTH CARE/MEDICAL

Upon completion of this section you will:

- Understand medical issues and symptoms of emergency medical situations related to your disability.
- Be able to identify personal medical problems.
- Be able to acquire/maintain appropriate medical assistance.
- Be able to prevent emergency health situations and determine the severity of health/medical emergencies.
- Develop TTY typing skills, if applicable.
- Be able to communicate effectively on TTY to agencies, vendors and individuals and to contact the message relay service, if applicable.

B: EMERGENCY MEDICAL PROCEDURES

- Objective 1
 - Post in central, accessible location.
 - Have family member, neighbor, support person, etc. understand equipment.
 - Know and be able to instruct PCA in equipment use.
- Objective 2
 - Know and be able to explain to PCA past medical history.
 - Know and be able to instruct PCA in preventive measures relative to your disability.
 - If ill, know how to notify your physician.
 - List signs and symptoms of emergencies.

- Objective 3
 - Have a phone/TTY that can be used independently in or out of bed.
 - List all emergency telephone numbers.
 - Police
 - Fire Department
 - Ambulance
 - Preferred Hospital
 - Primary Physician
 - Consulting Physicians
 - Family members
 - Reliable neighbors
 - Support people
 - Center for Living & Working, Inc. (508) 798-0350
 - PCAs
 - Back-up PCAs
 - Relay Service (800) 439-2370
 - Post emergency numbers in central and accessible location.
 - Be aware of community policies on snow emergencies.

DISABILITY INDICATOR FORM

Important Information and Instructions

You are required to complete this form if you want your police department, fire department, or other emergency agency to know about you when you call 9-1-1 in an emergency.

PLEASE NOTE: IT IS IMPORTANT TO SUBMIT A NEW DISABILITY INDICATOR FORM UPON CHANGE OF SERVICE PROVIDER, TELEPHONE NUMBER, OR ADDRESS.

When your 9-1-1 call is answered at your local Public Safety Answering Point, the 9-1-1 system automatically displays your name, address and telephone number on the dispatcher's screen.

At your request, codes will be displayed on the dispatcher's screen that will identify the disability indicators that have been reported for you or someone living with you at your address. These codes will help the dispatcher at the 9-1-1 Public Safety Answering Point to communicate with the caller and provide useful information to your responding public safety agency.

The information is confidential and will **only** appear at the dispatcher's location when a 9-1-1 call originates from **your** address.

The information you provide for input to the 9-1-1 system will remain until you request a change or make a request to have it removed. **It is your responsibility to notify your 9-1-1 Municipal Coordinator when there is a change in the information described on this form.** When there is a change, complete another form and send it to your 9-1-1 Municipal Coordinator.

If the disability indicator form is not completed properly, the information will not be entered into the 9-1-1 system.

When filling out the form, be sure to:

- 1 Give your telephone number, name, and address
- 2 Check the box or boxes
- 3 Sign and date the form
- 4 Return the form to your 9-1-1 Municipal Coordinator for processing

Any questions should be referred to your 9-1-1 Municipal Coordinator at:

Name: _____

Telephone Number: _____

9-1-1 MUNICIPAL COORDINATORS:

RETAIN ORIGINAL FOR YOUR RECORDS

All forms must be signed by both parties or it will be returned.

**Fax all disability indicator forms to Verizon 9-1-1 Database Management at
1-800-839-6020**

9-1-1 Disability Indicator Form-Individual Record

The filing of this document with your 9-1-1 Municipal Coordinator will alert public safety officials that an individual residing at your address communicates over the phone by a TTY and/or has a disability that may hinder evacuation or transport. This information is confidential and will **ONLY** appear at the dispatcher's location when a 9-1-1 call originates from **your** address.

PLEASE NOTE: IT IS IMPORTANT TO SUBMIT A NEW DISABILITY INDICATOR FORM UPON CHANGE OF SERVICE PROVIDER AND ADDRESS.

Telephone Number: Area code (_____) _____ Voice TTY
Telephone Service Provider _____
Name: _____
Address: _____
Town & Zip code: _____

Please check approved designations for inclusion in the 9-1-1 Database to assist public safety dispatchers in responding to an emergency at your address: **Any changes should be communicated to your 9-1-1 Municipal Coordinator promptly.**

Check all that apply to indicate that someone at the address:

- ☐ **"LSS" Life Support System:** has equipment required to sustain their life.
- ☐ **"MI" Mobility Impaired:** is bedridden, wheelchair user or has another Mobility Impairment.
- ☐ **"B" Blind:** is legally blind.
- ☐ **"DHH" Deaf or Hard of Hearing:** is deaf or hard of hearing.
- ☐ **"TTY":** communication via the phone may be by TTY.
- ☐ **"SI" Speech Impaired:** has a speech impairment.
- ☐ **"CI" Cognitively Impaired:** is cognitively impaired.
- ☐ **PLEASE REMOVE any designation presently on file.**
- ☐ **PLEASE CHANGE existing designators to those shown above.**

NOTICE: By initiating this document I understand that I am responsible for notifying my 9-1-1 Municipal Coordinator of any changes with regard to the status of the above disability indicator(s). I further agree, I will indemnify, defend and hold the State 911 Department, Verizon, my public safety dispatch location and municipality harmless from and against any claims, suits and proceedings (including attorney fees associated therewith) resulting from or arising out of the initial provision or updating of this information.

I understand this information will remain as part of my 9-1-1 record until such time as I notify my 9-1-1 Municipal Coordinator to changing or delete the same.

Signed : _____ (Customer) DATE: _____

Signed: _____ (Municipal Coordinator) DATE: _____

EMERGENCY PROCEDURE

Name: _____ D.O.B. _____

Address: _____

Home Phone # _____ S.S. # _____

Disability: _____

Communication Requirements: _____

Medication Taken & Quantities

Allergies: _____

Health Insurance:

MH# _____ Medicaid # _____ Medicare # _____

Hospital Preferred: _____

Primary Care Doctor: _____ Phone # _____

Address: _____

Person to Notify in case of an Emergency or Urgent Concern:

Name	Relationship	Address	Phone
1.			
2.			
3.			

EMERGENCY PROCEDURE

Special Instructions: _____

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

C: HOW/WHERE TO REQUEST A SIGN LANGUAGE INTERPRETER FOR LEGAL EMERGENCIES AND GENERAL REQUESTS:

FOR LEGAL EMERGENCIES:

CALL MCDHH AT 800-249-9949 VOICE/TTY
(24 hours 7 days/week)

MCDHH will request a certified legal interpreter, with specialized legal training
For legal emergency/situations (abuse/neglect, court-related, etc.).

FOR GENERAL/NON-LEGAL SIGN LANGUAGE INTERPRETER REQUESTS:

Contact MCDHH (Massachusetts Commission for the Deaf and Hard of Hearing):

- 1) **Call 617-740-1600. Non-emergency requests** are received between **8:45 a.m. and 5:00 p.m. Monday through Friday**. The interpreter referral specialist will ask you for the date, time, and location of the meeting/training/conference as well as the names of individuals (Deaf and non-Deaf) attending and the billing information. If you don't connect with a live person and have to leave a message, just leave your name and phone number for them to call back. If you don't receive a return call within a day, call back to try to connect with someone to place the request.
- 2) **Go to <https://www.mcdhh.net/request/>** and fill-out the online form. You will receive an automatic reply showing that your online request has been submitted. An interpreter referral specialist will then send you an email with an Order ID# for your interpreter request, explaining that your request is being processed. A separate confirmation email, or email stating that they were unable to secure an interpreter, will typically be sent to you close to the date of the meeting. Before then, you can call the phone # above to check on the status of the request any time; it's recommended that you do so.

And/or contact **The Learning Center for the Deaf (TLC) in Framingham** (during normal business hours):

- 3) **The Learning Center for the Deaf - Interpreting Services**
848 Central Street, Framingham, MA 01701
V/TTY: (508) 879-5110
interpreter_request@tlcdeaf.org

If you email TLC at the email address above, they would need the same type of information as MCDHH – date, time, location, attendees, billing info, etc. They also just launched a new online interpreter request system that they will add your request to and possibly setup a username and password for you for future requests.

******When requesting ASL interpreters, due to the high demand for interpreters, you should request them at least 2-3 weeks in advance.******

Section VI:

Fiscal Intermediary Service

A: SAMPLE PCA EMPLOYMENT PACKET

NEW HIRE PACKET

PART 1—IMPORTANT—MANDATORY FORMS

ALL of the forms in Part 1 of the New Hire Packet are MANDATORY for all PCAs, and must be completed in full and sent together to Stavros FI.

Failure to complete paperwork properly and in full, and to provide the supporting documents required, will delay Stavros FI from processing your initial payroll.

PLEASE READ ALL ENCLOSED INSTRUCTIONS CAREFULLY

Use this page as a checklist to ensure that you have completed **ALL** mandatory forms:

- ☐ New Hire Form —to be completed by the Consumer and PCA
 —provides us with accurate contact information for
 Consumer and PCA
- ☐ PCA Signature Form —to be completed by the PCA
 —PCAs acknowledgement of responsibility for caring for
 the Consumer
- ☐ I-9 Form —to be completed by the Consumer and PCA
 —Federal Government document demonstrating that the
 PCA is legally eligible to work in the U.S.
- ☐ W-4 Form —to be completed by the PCA
 —Federal Government document providing your Federal tax
 information
- ☐ Direct Deposit Choice —required by Mass Health for all PCAs
 —authorizes Stavros to deposit your payroll, and provides
 proof of account

Fax these completed forms & all supporting documents to: 413-256-3596 or 888-773-4281 or 413-256-3849

Or mail them to: Stavros FI, PO Box 2130, Amherst MA 01004

Or drop them off at: Stavros Center For Independent Living, 210 Old Farm Road, Amherst MA 01002

Or drop them off at: Stavros, 227 Berkshire Avenue, Springfield MA 01109

Consider union membership in United Healthcare Workers East (not mandatory). See the 1199SEUI Application For Membership.

New Hire Form

PLEASE COMPLETE AND SEND ALONG WITH THE COMPLETED W-4, I-9, PCA SIGNATURE FORM AND DIRECT DEPOSIT APPLICATION.

PCA NAME: _____

PCA ADDRESS: _____

PCA SOCIAL SECURITY NUMBER: _____

PCA DOB: _____ DATE OF HIRE: _____

PCA HOME PHONE #: _____ PCA CELL PHONE #: _____

PCA EMAIL ADDRESS: _____

PLEASE MAKE SURE THE FOLLOWING REQUIRED FORMS ARE FULLY COMPLETED AND SIGNED:

☐ W-4 (COMPLETED AND SIGNED BY PCA) ☐ I-9 (COMPLETED AND SIGNED BY PCA AND CONSUMER)

☐ IDs (PLEASE REVIEW THE LIST OF ACCEPTABLE DOCUMENTS ON PAGE 3 OF THE I-9)

☐ PCA SIGNATURE FORM (COMPLETED AND SIGN BY PCA)

☐ DIRECT DEPOSIT APPLICATION (COMPLETED AND SIGNED BY PCA WITH SUPPORTING DOCUMENTATION OF ACCOUNT ATTACHED)

EMPLOYER NUMBER:

--	--	--	--

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER HOME PHONE #: _____ EMPLOYER CELL PHONE #: _____

Personal Care Attendant Signature Form

MassHealth

THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Name of fiscal intermediary (FI) _____

- All PCAs hired by a PCA consumer must fill out and sign this form and give it to their employer (the PCA consumer).
- The PCA's employer (the PCA consumer) must submit this form to the FI, along with all other paperwork required by the FI and MassHealth.
- The FI cannot pay a PCA until all required paperwork is received and complete.
- MassHealth and the FI cannot pay a PCA to work
 - when the PCA consumer is in an inpatient facility, such as a hospital or nursing facility; or
 - when the amount of time that has been authorized by MassHealth has been exhausted or is insufficient.
- The PCA must read the rest of this form and sign below before receiving payment from the FI.

I agree to accept the position of personal care attendant (PCA) for _____
(name of PCA consumer).

I understand that my employer is the PCA consumer. My employer is responsible for hiring, firing, training and scheduling PCAs. My employer may select another person (a surrogate) to help manage his or her PCA services. I must notify my employer and the surrogate (if any), of any changes in my circumstances that would affect my ability to perform my duties as a PCA. I must complete and provide accurate Activity Forms (time sheets) to my employer or the FI as soon as I can. The FI will process payroll for my employer. My employer is responsible for giving the check to me (unless I requested that my check be deposited directly into my bank account). I must provide proof of my identity to my employer to complete the Employment Eligibility Verification form (Form I-9), which the Department of Homeland Security requires all employees to complete. (The FI will give my employer this form.)

I understand that the MassHealth PCA program pays for personal care services provided by a PCA only when the PCA provides physical assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to an eligible PCA consumer who has obtained prior authorization from MassHealth for PCA services. PCA services must be provided in accordance with the PCA consumer's authorized PCA evaluation or reevaluation, service agreement, and MassHealth regulations at 130 CMR 422.410.

I understand that ADLs include physically assisting the PCA consumer with transferring, walking, using medical equipment, taking medications, bathing and grooming, dressing and undressing, passive range-of-motion exercises, eating, and toileting. I understand that IADLs include household services that are essential to the PCA consumer's care such as laundry, shopping, housekeeping, meal preparation and cleanup, transportation to medical appointments, activities such as maintenance of wheelchairs or other medical equipment, completing the paperwork required for receiving personal care services, and other activities approved by MassHealth as being instrumental to the health care needs of the PCA consumer.

I understand that my employer (the PCA consumer) will tell me which of these services require me to provide physical assistance.

I understand that I cannot be paid as a PCA if I am a spouse, parent (if the PCA consumer is a minor child), surrogate, foster parent, or legally responsible relative of the PCA consumer.

The following describes my relationship to my employer (the PCA consumer). (Please check one.)

- | | | |
|--|--|---|
| <input type="checkbox"/> adult child (18 yrs. or older) of member | <input type="checkbox"/> daughter-in-law of member | <input type="checkbox"/> son-in-law of member |
| <input type="checkbox"/> parent of adult (18 yrs. or older) member | <input type="checkbox"/> other relative (describe) | <input type="checkbox"/> nonrelative (describe) |

I certify under pains and penalties of perjury that the information on this signature form, and any accompanying statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete to the best of my knowledge. I also certify that I understand my duties, rights, and responsibilities as a PCA and that all the information I have provided to my employer (the PCA consumer), to the fiscal intermediary, to the personal care management agency, or to MassHealth is true and accurate to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Print PCA Name _____ Date _____

PCA signature _____

Completing the Form I-9 Employment Eligibility Verification

All PCA new hires must complete a Form I-9. The Form I-9 can be completed electronically or on paper. If completing the I-9 electronically, please remember it still must be printed out and signed by both the PCA and the consumer/surrogate.

A completed Form I-9 must be submitted along with the rest of a PCAs required new hire paperwork to Stavros FI. Incomplete or incorrectly completed Form I-9s will delay the setup of any new PCA.

Please remember these important items when completing an I-9 with a PCA new hire.

- Section 1
 - Must be completed by the PCA.
 - If the PCA is unable to complete it by themselves, the individual who assists them with Section 1 must complete the Preparer and/or translator certification.
 - The PCA must sign and date the I-9 in the space provided in Section 1.
- Section 2
 - Must be completed by the consumer and/or their surrogate.
 - Please make sure that proper documentation is used to complete this section. Please refer to the Lists of Acceptable Documents for what identification can be used.
 - Completing Section 2 requires an ID from List A **or** IDs from both List B **and** List C.
 - Social Security cards containing any of the following language cannot be used:
NOT VALID FOR EMPLOYMENT; VALID FOR WORK ONLY WITH INS
AUTHORIZATION; OR VALID FOR WORK ONLY WITH DHS AUTHORIZATION.
 - Expired documents *cannot* be used to complete Section 2.
 - The consumer and/or surrogate must sign the Form I-9 following Section 2.
- Section 3
 - Only needs to be completed if a PCA is being rehired within three years of the completion of their original Form I-9.
- For complete instructions on completing the Form I-9 please visit <https://www.uscis.gov/i-9>. The instructions are also located in the Forms section of our website www.stavrosfi.org. If you do not have internet access and need a copy of these instructions, please contact Stavros FI to request a copy.



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		Employee's E-mail Address			Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>
<p>QR Code - Section 1 Do Not Write In This Space</p>

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
-------------------------------------	-------------------------	-------------------------	------	--------------------------------

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
--	---------------------------	---

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)			
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
4. Employment Authorization Document that contains a photograph (Form I-766)			
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		3. School ID card with a photograph	3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
		4. Voter's registration card	
		5. U.S. Military card or draft record	
		6. Military dependent's ID card	4. Native American tribal document
		7. U.S. Coast Guard Merchant Mariner Card	
		8. Native American tribal document	5. U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		For persons under age 18 who are unable to present a document listed above:	6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		10. School record or report card	
		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

..... Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074	
		▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		2019	
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."			
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ <input type="checkbox"/>			
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2019, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶				Date ▶	
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)		9 First date of employment		10 Employer identification number (EIN)	

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter “-0-” on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at www.irs.gov/W4App. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you

don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero (“-0-”) on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at www.irs.gov/W4App to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the “Married, but withhold at higher Single rate” box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the “Married, but withhold at higher Single rate” box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9,

and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to www.acf.hhs.gov/css/employers.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A _____
B	Enter "1" if you will file as married filing jointly	B _____
C	Enter "1" if you will file as head of household	C _____
D	Enter "1" if: $\left\{ \begin{array}{l} \bullet \text{ You're single, or married filing separately, and have only one job; or} \\ \bullet \text{ You're married filing jointly, have only one job, and your spouse doesn't work; or} \\ \bullet \text{ Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.} \end{array} \right\}$	D _____
E	Child tax credit. See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from \$179,051 to \$200,000 (\$345,851 to \$400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" E _____	
F	Credit for other dependents. See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than \$179,050 (\$345,850 if married filing jointly), enter "-0-" F _____	
G	Other credits. If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F G _____	
H	Add lines A through G and enter the total here	H _____

For accuracy,
complete all
worksheets
apply.

• If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.

• If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$53,000 (\$24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.

• If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	1 \$ _____
2	Enter: $\left\{ \begin{array}{l} \$24,400 \text{ if you're married filing jointly or qualifying widow(er)} \\ \$18,350 \text{ if you're head of household} \\ \$12,200 \text{ if you're single or married filing separately} \end{array} \right\}$	2 \$ _____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3 \$ _____
4	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4 \$ _____
5	Add lines 3 and 4 and enter the total	5 \$ _____
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	6 \$ _____
7	Subtract line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7 \$ _____
8	Divide the amount on line 7 by \$4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8 _____
9	Enter the number from the Personal Allowances Worksheet , line H, above	9 _____
10	Add lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 of that worksheet on page 4. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10 _____

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1** Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) **1** _____
 - 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" **2** _____
 - 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____
- Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4** Enter the number from line 2 of this worksheet **4** _____
 - 5** Enter the number from line 1 of this worksheet **5** _____
 - 6** **Subtract** line 5 from line 4 **6** _____
 - 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____
 - 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____
 - 9** **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,900	\$420	\$0 - \$7,200	\$420
5,001 - 9,500	1	7,001 - 13,000	1	24,901 - 84,450	500	7,201 - 36,975	500
9,501 - 19,500	2	13,001 - 27,500	2	84,451 - 173,900	910	36,976 - 81,700	910
19,501 - 35,000	3	27,501 - 32,000	3	173,901 - 326,950	1,000	81,701 - 158,225	1,000
35,001 - 40,000	4	32,001 - 40,000	4	326,951 - 413,700	1,330	158,226 - 201,600	1,330
40,001 - 46,000	5	40,001 - 60,000	5	413,701 - 617,850	1,450	201,601 - 507,800	1,450
46,001 - 55,000	6	60,001 - 75,000	6	617,851 and over	1,540	507,801 and over	1,540
55,001 - 60,000	7	75,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 95,000	8				
70,001 - 75,000	9	95,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 110,000	10				
85,001 - 95,000	11	110,001 - 115,000	11				
95,001 - 125,000	12	115,001 - 125,000	12				
125,001 - 155,000	13	125,001 - 135,000	13				
155,001 - 165,000	14	135,001 - 145,000	14				
165,001 - 175,000	15	145,001 - 160,000	15				
175,001 - 180,000	16	160,001 - 180,000	16				
180,001 - 195,000	17	180,001 and over	17				
195,001 - 205,000	18						
205,001 and over	19						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to

cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating

to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

DIRECT DEPOSIT SELECTION—*MANDATORY*

All PCAs must make a Direct Deposit choice at the time of hire (please see the accompanying letter from MassHealth, provided in English and Spanish). ***We cannot process your New Hire Paperwork or payroll without your direct deposit selection.*** Read all information enclosed before selecting the option that is best for you. Choose ***ONE*** of the following three options, complete the forms as instructed, and submit them with supporting documents to Stavros FI with all other mandatory forms:

Option 1—Direct Deposit using your existing checking, savings, or online account

Complete the Direct Deposit Authorization Form (Authorization Agreement for Personal Assistance Direct Deposits). This must be filled out completely, including your account number and routing number, and your signature authorizing Stavros FI to deposit to your account.

Provide proof of account.

For a checking account, submit a voided check with your name printed on it (we cannot accept starter checks as proof of account), or a letter/form from your bank which provides your name, account, and routing number.

For a savings account, submit a letter/form from your bank which provides your name, account, and routing number.

For an online bank, go to the bank website, print your account and routing number, and submit the printout.

Option 2—Green Dot Debit Card—*EASY APPLICATION!*

To apply, go online to [GreenDot.com/1199SEIU](https://www.GreenDot.com/1199SEIU). You can also find this link at stavrosfi.org under “Forms”. When you have successfully registered, print the account and routing numbers provided by Green Dot as proof of your account. ***Complete the Direct Deposit Authorization Form using these account numbers and submit both the signed Direct Deposit form and proof of account to Stavros FI.***

IMPORTANT

If your properly completed timesheet is received by Stavros FI on the Monday it is due, your deposit should occur by Friday of the same week. Deposits can happen earlier than Friday, but deposits should NOT be expected OR anticipated before Friday—PAYDAY IS OFFICIALLY EVERY OTHER FRIDAY.

**Your consumer will receive a non-negotiable pay stub for each of your deposits—
be sure to get your stubs from your consumer for your records.**



CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

Personal Care Attendant Quality
Home Care Workforce Council
600 Washington Street, 7th Floor
Boston, Massachusetts 02111

Tel: (617) 348-5317
www.mass.gov/pca
Email: pcacouncil@state.ma.us
Facebook:
www.facebook.com/MassPCA

November, 17, 2016

MassHealth Personal Care Attendant (PCA) Program

Notice to PCAs about New Payroll Requirements

This notice is to inform you about changes in how you are paid for PCA services. These changes are required by the collective bargaining agreement between the Commonwealth of Massachusetts's PCA Workforce Council and the PCA union (1199SEIU).

- **Beginning January 1, 2017, you are required to have direct deposit for PCA services.**
- If you can't get direct deposit, you may apply for another payment method from the options below.

If you already use direct deposit to be paid for PCA services, you do not have to do anything.

What You Need to Know, and What Steps You Must Take

Apply for Direct Deposit

- A direct-deposit application form is attached to this notice. Complete the application and return it to the address on the application.
- **Note: Direct-deposit accounts must be in the name of the PCA only. The account can't be a joint account that you share with the consumer or the surrogate.**

If You Can't Get Direct Deposit, You Must Apply for a Payroll Debit Card

- If you don't have a bank account that accepts direct deposit, you must apply for a **payroll debit card**. Ask either your fiscal intermediary (FI) or the union for a payroll debit card application.
- **Note: If you apply for a payroll debit card, be sure to read all of the terms and conditions, which will tell you when any fees may apply.**

If You Can't Get Paid by Direct Deposit or Payroll Debit Card, You Must Apply for an Exemption

- You may apply for an exemption *only* if you can't enroll in direct deposit or get a payroll debit card due to a severe hardship. Examples of hardship may include: you can't access a bank or financial institution during off-hours; there's no ATM within a reasonable distance of your work or home; or the PCA is a minor. If you do get an exemption, you'll be paid by a paper check for PCA services. The PCA Workforce Council, together with your Fiscal Intermediary (FI) and the PCA union, will review your request and make a decision. Note: Preferring to be paid by check is not a hardship.
- Contact your FI to obtain the direct-deposit form or debit card payroll exemption application, and return the completed form to your FI.

Contact your FI if you do not understand the information in this notice or if you have any questions about it.

Please submit your direct-deposit form, debit card application, or exemption request as soon as possible.



Bank Name: _____

Bank Address: _____
(City) (State)

Depositor Account No: _____

Type of Account: ☐ Checking ☐ Savings ☐ Debit Card
(Attach proof of acct.) (Attach proof of acct.) (Attach proof of acct.)

TRANSIT ROUTING NUMBER

ACCOUNT NUMBER INFORMATION

$$\begin{array}{ccccccc} : & | & | & | & | & \dots & | & | & | & | \\ : & | & | & | & | & \dots & | & | & | & | \end{array}$$

Stavros **will not process a direct deposit request** without supporting documentation from the financial institution attached to the authorization agreement. Please contact Stavros FI's customer service department if you have any questions about what supporting documentation is acceptable.

The Personal Care Attendant's (PCA) **name must be on the account.**

Stavros **will not accept an account that has the name of the consumer and/or surrogate** as an account holder.

PCA NAME: _____

PCA SOCIAL SECURITY NUMBER:

EMPLOYER (CONSUMER) NUMBER: _____

EMPLOYER (CONSUMER) NAME: _____

DATE: _____ PCA SIGNATURE: _____

I hereby authorize Stavros FI as Fiscal Intermediary for my employer (consumer) to deposit my net pay at the financial institution named above. I understand the Stavros FI may cause my account to be adjusted to the extent necessary to correct any over-deposit and I agree to hold the above named financial institution harmless for any erroneous deposits or adjustments not caused by the financial institution.

It is understood this agreement may be terminated by me at any time by written notification to Stavros FI. Any such notification to Stavros FI shall be effective only with respect to entries initiated by Stavros FI after receipt of such notification and a reasonable opportunity to act on it. Any such notification to the BANK by the PCA is unacceptable. The BANK may terminate this agreement by written notice to the PCA for just cause.

Below is a sample check detailing where the information necessary to complete this form can be found.

John Q. Public
Jane Q. Public
111 Main Street
Anywhere USA 02341

0101

Date: _____

Pay to the Order of _____ \$ _____

_____ DOLLARS

MAIN STREET BANK
3000 Main Street
Anywhere USA 02341

Memo: _____

Checking Account #
(Always between these 2 marks)

Routing /Transit #
(a 9-digit number Always between The two marks)

Check #
(not needed for sign-up)

PLEASE CHECK TO SEE IF FUN DS HAVE BEEN DEPOSITED INTO YOUR ACCOUNT. STAVROS FI WILL NOT BE LIABLE FOR ANY OVERDRAFT FEES INCURRED DUE TO DELAYS IN DIRECT DEPOSIT.

Starting January 1, 2017 PCAs will be paid through either direct deposit to a checking account or a debit card

Get paid up to 2 days earlier with direct deposit.*

*Subject to your payment provider's process and timing.

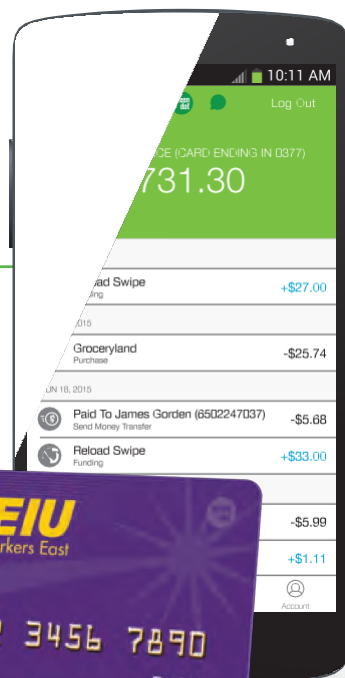
- ✓ No commitments
- ✓ No obligations
- ✓ No overdraft Fees ever



Get your paycheck loaded to a Green Dot card today!

Here's how:

- 1 Get a card at **GreenDot.com/1199SEIU**
You do not need to have a checking account to sign up.
- 2 After successful registration, receive your direct deposit numbers online or call our direct deposit hotline at (866) 795-7974.
- 3 Complete the direct deposit form in this mailer and simply bring it to your payroll supervisor.



Get a card at **GreenDot.com/1199SEIU**

Use it everywhere that MasterCard Card® debit cards are accepted in the US

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APPLICATION FOR MEMBERSHIP

1199SEIU
United Healthcare Workers East

SECTION 1. MEMBERSHIP AGREEMENT Membership in 1199SEIU is without regard to race, color, sex, sexual orientation, age, disability, religion, national origin, political belief or affiliation. **YES**, I want to join healthcare workers across the state for a stronger voice for quality healthcare, living wages, and good benefits. I accept membership in 1199SEIU United Healthcare Workers East and designate 1199 to act for me as collective bargaining agent in all matters pertaining to conditions of employment. I pledge to abide by the Constitution of 1199SEIU United Healthcare Workers East.

SIGNATURE

DATE

SECTION 2. CHECK OFF AUTHORIZATION* I recognize the need for a strong Union and believe everyone represented by our Union should pay their fair share to support our Union's activities. You are authorized and directed to deduct an initiation fee from my wages or salary as required by 1199SEIU United Healthcare Workers East as a condition of my membership; and in addition, to deduct my membership dues from my wages or salary, including with respect to any union dues or initiation fees that have been previously paid in this manner; and in addition, to deduct each month an amount equal to monthly membership dues to be applied to past unpaid dues until the entire amount of unpaid past dues has been deducted and paid; and to remit all such deductions to 1199SEIU United Healthcare Workers East, 310 W. 43rd Street, New York, NY 10036, no later than the tenth day of each month immediately following the date of deduction, or pursuant to the date provided in the Collective Bargaining Agreement. This deduction is a voluntary act on my part. This authorization may be withdrawn pursuant to M.G.L. c. 180 § 17A upon my giving at least sixty days' notice in writing of such withdrawal to the Commonwealth or its designated fiscal intermediary and my sending a copy of such withdrawal to the 1199SEIU Dues and Membership Department at 310 W. 43rd Street 2nd Floor, New York, NY 10036. **I acknowledge that contributions, gifts, and dues payments to 1199SEIU United Healthcare Workers East are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses.*

SIGNATURE

DATE

SECTION 3. DIRECT PAY AUTHORIZATION In the event my employer ceases payroll deductions and 1199SEIU provides me with a transition notice notifying me of the change, I authorize 1199SEIU to bill my credit card account or make withdrawals from my bank account, in accordance with this Direct Pay Authorization. 1199SEIU will notify me of the transition to direct pay at the current mailing address on file with 1199SEIU prior to initiating the first payment via credit card, checking, or savings account. I authorize 1199SEIU to initiate a recurring, automatic electronic funds transfer with my financial institution in order to deduct from the account provided to 1199SEIU through a secure portal 2% of my biweekly gross pay, with a current minimum of \$0.29 and a current maximum of \$46.59 in a 4 week period on the day after every payday designated by my Fiscal Intermediary. Those deductions will begin on the date listed in the transition notice, provided that date is at least ten (10) days after 1199SEIU mails the notice. The dues amount may change if authorized according to the requirements of the 1199SEIU Constitution. If this happens, I authorize 1199SEIU to initiate a recurring, automatic funds transfer in the amount of the new dues amount when notified by 1199SEIU in writing of the new amount and with at least ten (10) days' notice before the next funds transfer date. In the case of checking and savings accounts, I also authorize adjusting entries to correct errors. I agree that these withdrawals and adjustments may be made electronically and subject to the Rules of the National Automated Clearing House Association. This authorization shall remain in effect until I revoke my authorization using the process described in Section 2. I acknowledge that failure to pay my dues on a timely basis may affect my membership standing in the union, as set forth in the 1199SEIU Constitution. **To provide my authorization for direct payments from my account, I am providing my signature on the line below.**

Q RELEASE I authorize my employer, or its fiscal agent, to provide only to 1199SEIU's designated secure payment processor, TD Bank, the information for the bank account (bank account number, account holder's name and routing number) on file with my employer ("Account") that I have designated to receive the proceeds of my paycheck via direct deposit, and for my dues, contributions to the 1199SEIU Massachusetts Political Action Fund, and/or other payments I have authorized to be deducted from this Account on the day after every payday designated by my employer. If my employer makes direct deposit of my paycheck to a checking account and a savings account, I hereby authorize my employer to provide to TD Bank the information for the checking account and for my dues, Political Action Fund contributions, and/or other contributions to be deducted from this account on the day after every payday designated by my employer. I understand that after TD Bank receives my Account information, 1199SEIU will make reasonable efforts to contact me via U.S. mail to confirm the accuracy of the Account information provided by my employer at least 10 days in advance of making the first electronic funds transfer from my Account.

SIGNATURE

DATE

SECTION 4. 1199SEIU MASSACHUSETTS POLITICAL ACTION FUND The 1199SEIU Massachusetts Political Action Fund builds strength for healthcare and homecare workers. By uniting our voices and growing our political power, healthcare and homecare workers can be stronger advocates for our jobs and the people in our care. Elected officials make decisions that directly impact funding for our jobs and the services we provide. Together, we can elect leaders who respect healthcare and homecare workers and who honor the work that we do.

I hereby authorize 1199SEIU United Healthcare Workers East to file this payroll deduction form on my behalf with my employer to withhold **Q \$10 per month, Q \$15 per month or Q \$ per month** and forward that amount to the 1199SEIU Massachusetts Political Action Fund, 330 W. 42nd St., 7th floor, New York, NY 10036.

In the event my employer ceases payroll deductions, I authorize 1199SEIU to initiate a recurring, automatic electronic funds transfer with my financial institution consistent with the terms of Section 3, beginning on the date listed in the transition notice provided to me in order to deduct the amount specified above from the designated account referenced in Section 3. My signature below shows my agreement to apply the terms of Section 3 to deduction of my Political Action Fund contributions.

This authorization is made voluntarily based on my specific understanding that: (1) I am not required to sign this form or make voluntary contributions to the 1199SEIU Massachusetts Political Action Fund as a condition of my employment or membership in the union; (2) I may refuse to contribute without reprisal; (3) Under law, only union members and executive/administrative staff who are U.S. Citizens or lawful permanent residents are eligible to contribute to the Political Action Fund; (4) the contribution amounts on this form are merely suggestions, and I may contribute more or less by this or other means without fear or disadvantage from 1199SEIU or my employer; (5) 1199SEIU Massachusetts Political Action Fund uses the money it receives for political purposes – including, but not limited to, making contributions to and expenditures on behalf of candidates for federal, state, and local offices – and addressing political issues of public importance. This authorization shall remain in effect until revoked by me in writing to 1199SEIU via U.S. mail as described in Section 2. *Contributions or gifts to 1199SEIU Massachusetts Political Action Fund are not tax deductible as charitable contributions.*

SIGNATURE

DATE

NAME (PRINT)

PCA#

ADDRESS

CITY

STATE

ZIP

HOME PHONE

CELL PHONE+

EMAIL

LAST 4 DIGITS SSN

BIRTHDAY

+By providing my phone number, I understand the Service Employees International Union, its local unions, and affiliates may use automated calling technologies and/or text message me on my cellular phone on a periodic basis. SEIU will never charge for text message alerts. Carrier message and data rates may apply to such alerts. Text STOP to 30644 to stop receiving messages. Text HELP to 30644 for more information.

Q I want to get involved in 1199SEIU! Please have an organizer follow up with me.

FOR INTERNAL USE ONLY

1199SEIU 

STAVROS

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CARD COLLECTED BY:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

LAST FOUR DIGITS OF COLLECTOR'S SSN#

NEW HIRE PACKET

PART 2—OPTIONAL FORMS AND INFORMATION

Part 2 contains both optional forms and informational material.

If you elect to complete any of the **optional** forms in Part 2, submit them to Stavros FI along with the mandatory forms from Part 1.

These **optional** forms are:

1. *Massachusetts Employee's Withholding Exemption Certificate*—provides any Massachusetts withholdings you want from your Massachusetts income tax, in addition to the Federal tax provided in the W-4 form
2. *Stavros User Portal Agreement*—allows PCAs and Consumers to submit timesheets electronically. To use this system, the PCA and Consumer must each submit a Portal Agreement.

The remaining materials in Part 2 are ***for your information only***. Please keep these materials for your reference.

These **informational** materials are:

1. Portal Instructions for tracking PCA Sick Time
2. PCA Overtime Update (*provided in English and Spanish*)
3. Workers Compensation Claims Reporting Procedures

FORM
M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 1/12



Print full name
Print home address

Social Security no.
City State Zip

Employee:

File this form or Form W-4 with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2"
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C.....
3. Write the number of your qualified dependents. See Instruction D.....
4. Add the number of exemptions which you have claimed above and write the total.....
5. Additional withholding per pay period under agreement with employer \$
 - A. ☐ Check if you will file as head of household on your tax return.
 - B. ☐ Check if you are blind.
 - C. ☐ Check if spouse is blind and not subject to withholding.
 - D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed \$8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date Signed

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. If you claim **more** than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive over withholding, unless you have a significant amount of other income.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions **increases**. You **must** file a new certificate within 10 days if the number of exemptions previously claimed by you **decreases**. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write "4" in line 2. Using "4" is the withholding system adjustment for the \$4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.



Dear PCA,

We want to tell you about a **new update** to the PCA overtime requirements.

Since August, MassHealth has been working with PCA consumers and other stakeholders about managing PCA overtime. Based on the feedback we received, MassHealth has made important changes to the PCA overtime requirements. MassHealth is increasing the number of hours a PCA can work before an overtime approval is required to **50 hours per week**. Additionally, MassHealth has updated the consumer/employer overtime approval criteria.

This letter replaces information sent out in earlier letters and FAQs on PCA overtime management.

What changes have been made to PCA Overtime Management?

The number of hours one PCA can work providing MassHealth PCA services without requiring overtime approval has increased to **50 hours each week**. The 50-hour limit applies whether the PCA works for one consumer, or for more than one consumer.

MassHealth has also developed new criteria to better reflect consumer/employer's needs in determining whether your consumer/employer will be approved to schedule an individual PCA to work more than 50 hours per week.

What do I have to do now?

If you work more than 50 hours per week for one or more consumers, talk to your consumer/employer(s) about your work schedule to make sure you and your consumer/employer(s) comply with the new overtime policy, or please ask each consumer/employer to submit an overtime request form.

If you have questions

You can contact your Fiscal Intermediary (FI) agency. Your FI will have all the latest information.

Sincerely,

MassHealth

STAVROS PORTAL USER AGREEMENT

EMPLOYER # _____

You have selected to utilize the Stavros Portal to submit your PCA timesheets to the Stavros Fiscal Intermediary for processing. You will be assigned a temporary password which you should change the first time you log into the Stavros Portal. By signing below, you agree to the following:

- I understand that I may submit my timesheets via the Stavros Portal (I also understand I may choose to submit them by fax or by mail)
- I agree that when I log into the Stavros Portal that I will establish my own password and that I will keep this password confidential
- I agree that an electronic signature is an acceptable form of approval for each timesheet submitted
- I agree that my electronic signature will have the same legal weight and effect as a written signature and I will use this signature to authorize, approve, and sign my electronic timesheets
- I further agree that I will continue to abide by all the terms of the Fiscal Intermediary Agreement I have already signed, and that I understand all my responsibilities as listed in that agreement.

ACUERDO DEL USO DEL PORTAL DE STAVROS

Usted ha seleccionado utilizar el Portal de Stavros para enviar sus hojas de tiempo de PCA al intermediario fiscal de Stavros para ser procesadas. A usted se le asignará una contraseña temporera la cual usted puede cambiar la primera vez que usted use el Portal de Stavros. Firmando abajo usted esta de acuerdo con lo siguiente:

- Yo entiendo que puedo enviar mis hojas de tiempo al Portal de Stavros (yo también entiendo que puedo escoger la opción de enviarlas por fax o por correo).
- Yo estoy de acuerdo que cuando yo vaya al Portal de Stavros yo escogeré mi propia contraseña y mantendré la contraseña confidencial.
- Yo estoy de acuerdo que la firma electrónica es una forma aceptable de aprobación para cada hoja de tiempo enviada.
- Yo estoy de acuerdo que mi firma electrónica tendrá el mismo afecto legal que una firma por escrito y usare esta firma para autorizar, aprobar y firmar mi hoja de tiempo electrónicamente.
- Yo estoy de acuerdo que continuare obedeciendo todos los términos del Acuerdo del Intermediario Fiscal que yo he firmado, y entiendo todas mis responsabilidades que estan escritas en el acuerdo.

Signature/Firma

Date/Fecha

Name (print)/Nombre en letra de molde

E-mail address/Correo electrónico

Please check one:/Favor de escoger una:

- ☐ I am a PCA Consumer, my four digit Employer Number is:/ Yo soy un Consumidor de PCA, los cuatro Números del empleador es: _____
- ☐ I am a Surrogate for a PCA Consumer, their four digit Employer Number is:/ Yo soy el Tutor/a para el Consumidor de PCA, sus cuatro Números del empleadores: _____
- ☐ I am a PCA employed by a Consumer in the F.I. Program/ Yo soy un PCA empleado por un Consumidor del Programa de F.I.

Earned Sick Time Balance – PCA

To access the PCA Portal, go to <https://www.OnlineEmployer.com/feapca>

1. If it is your first time logging in to the site, click the blue “PCA First Time Login” link, which will provide the format of the username and password. If you have already logged in before, enter your user name and password.

Welcome

This secure portal is intended for use by authorized Fiscal Employer Agent (FE/A) Employees and PCAs.

Login:
First initial of FirstName + LastName + last 4 of SSN

Password:
First initial of FirstName + First initial of LastName + DOB (mmddyyyy)

Login: [PCA First Time Login](#)

Password:

2. For first time users, once you have logged in, you will be asked to reset your password and enter your email address. The email address is required so we can email you a temporary password should you need to reset it in the future.

Manage Password/Email Address

User Name: genuser

Password:

Confirm Password:

Email Address: *

Valid Email is required to reset password.

3. Once logged in, you will see your Earned sick time balance and history.

Earned Sick Time

Week	Hours Worked	Sick Earned	Sick Used	Balance
Summary	72.00	1.00	1.00	0.00
06/27/2015	16.00	0.53	1.00	0.00
06/20/2015	14.00	0.47	0.00	0.47
06/13/2015	14.00	0.00	0.00	0.00
06/06/2015	28.00	0.00	0.00	0.00

4. From the menu bar, there are two available options:

Settings ▼

Log Out

- a. Settings – Drop down menu to change your password or update your email address.
- b. Log out – Log out of the portal.

MASSACHUSETTS PERSONAL CARE ATTENDANT PROGRAM

**WORKERS COMPENSATION CLAIMS REPORTING
PROCEDURES**

PCA'S ARE ELIGIBLE TO RECEIVE WORKERS COMPENSATION
INSURANCE BENEFITS IF THEY ARE INJURED \WHILE THEY ARE
WORKING

CALL ATLANTIC CHARTER INSURANCE COMPANY AND
REPORT THE INCIDENT **WITHIN 24 HOURS.**

Atlantic Charter Insurance Company
25 New Chardon Street
Boston, MA 02114-4721

617-488-6500 Main Number
617-488-6502 Fax Number

CALL STAVROS AND REPORT THE INCIDENT TO YOUR
FISCAL INTERMEDIARY

1-800-442-1185

Payroll Period

From Sunday

Through Saturday

		/			/		
		/			/		

STAVROS FISCAL INTERMEDIARY SERVICES

P.O BOX 2130, Amherst, MA 01004-2130

Tel: (413) 256-6692, (800) 442-1185

Fax: (888) 773-4281, (413) 256-3849

1 7761



Employer Information

Number:

Name

Address

City State Zip

Home Phone Cell Phone

Email

PCA Information

SSN:

Last 4 Digits Only

Name

Address

City State Zip

Home Phone Cell Phone

Email

EMPLOYER CHECK ONLY IF NEW ADDRESS, TELEPHONE, OR E-MAIL AND ATTACH CHANGE FORM

Week #1	Hour	Time In MIN.		Hour	Time Out MIN.		Tot. Day/Eve Hours 6 AM to Midnight Hours MIN.	Tot. Night Hours Hours
Sun		:	AM PM		:	AM PM		
Mon		:	AM PM		:	AM PM		
Tue		:	AM PM		:	AM PM		
Wed		:	AM PM		:	AM PM		
Thu		:	AM PM		:	AM PM		
Fri		:	AM PM		:	AM PM		
Sat		:	AM PM		:	AM PM		
Total Week 1								

PCA CHECK ONLY IF NEW ADDRESS, TELEPHONE, OR E-MAIL AND ATTACH CHANGE FORM

Week #1	Hour	Time In MIN.		Hour	Time Out MIN.		Tot. Day/Eve Hours 6 AM to Midnight Hours MIN.	Tot. Night Hours Hours
Sun		:	AM PM		:	AM PM		
Mon		:	AM PM		:	AM PM		
Tue		:	AM PM		:	AM PM		
Wed		:	AM PM		:	AM PM		
Thu		:	AM PM		:	AM PM		
Fri		:	AM PM		:	AM PM		
Sat		:	AM PM		:	AM PM		
Total Week 2								

By signing below, I certify under pains and penalty of perjury that I have received MassHealth PCA services from the PCA during the times described on this activity form; and I am not enrolled in Adult Foster Care or Group Adult Foster Care.

By signing below, I certify under pain and penalty of perjury that I have provided MassHealth PCA services to the consumer during the times described on this activity form.

INSTRUCTIONS FOR ACTIVITY TIME SHEET – A SEPARATE TIME SHEET MUST BE COMPLETED BY EACH PCA

REMINDER: MassHealth does not pay for activity time performed by a PCA while the consumer is inpatient in a hospital or nursing home or is enrolled in Adult foster Care or Group Adult Foster Care. Activity time performed by a PCA while the consumer is in a hospital or nursing home or enrolled in Adult Foster Care or Group Adult Foster Care is considered fraud and will be referred to the Bureau of Special Investigations.

PLEASE NOTE: MassHealth regulations state that the consumer has a responsibility to utilize PCA services in accordance with the number of Day/Evening hours per week and Night hours per night authorized by MassHealth.

MassHealth PCA regulations require PCAs to have their PCA payments direct deposited into their bank or debit card account.

Masshealth prohibits payment for PCA Activity time performed by a PCA whose name appears on the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)

1.) **Please mail, fax or deliver this signed timesheet by 12:00 P.M. on the Monday** after the biweekly cycle ends to ensure timely payment. Incomplete or illegible timesheets, or timesheets not signed by both employer/surrogate and the PCA will be returned. Please do not send the timesheet twice. Be sure to keep a copy of the timesheet for the employer's records.

2.) **Record the payroll period dates.** The payroll period runs for 2 weeks. Each week starts on Sunday and runs through Saturday. Please check the payroll calendar for your schedule.

3.) **Record the Employer and PCA information.** On the top left side of the timesheet, write the employer number (4 digits), name and address. On the top right side, write the last four digits of the PCA's social security number, name, address, home and cell phones and e-mail address. A timesheet missing any of this information may not be processed and may be returned. Please check box ☒, if employer or PCA has changes to address, phones and/or e-mail address and return with a completed change form.

4.) **Recording the activity time.** Please schedule PCAs to work in 15 minute increments, time for each day on the activity form must be recorded in 15 minute increments or we will need to round up to the next 15 minute increment. Please complete the timesheet indicating the time worked on each day, making sure to put in and out times.

- Hours worked from 6:00 AM through 12:00 AM (midnight) are *Day/Eve Hours* and hours worked from 12:00 AM (midnight) to 6:00 AM are *Night Hours*.
- There are 2 lines of boxes per day to record the hours and minutes the PCA worked, with circles to record AM or PM. The time the PCA started "Time In" should be recorded in hours and minutes and the circle for AM or PM should be filled in completely. Next, the time the PCA left "Time Out" should be recorded in hours and minutes and the circle for AM or PM should be filled in. Then, the total time for that shift should be recorded in hours and minutes. E.g. 8:00 AM to 10:15 AM equals a total time of 2:15.
- If the PCA came back and worked more hours later the same day, that information should be recorded in the second row on the same day.
- If your PCA worked more than two shifts on the same day, a separate timesheet is necessary. (Remember to fill out all the required information again.)

5.) **Night Activity Time.** You must have authorization from MassHealth to use *Night hours* between 12:00 AM (midnight) and 6:00 AM. If you are approved for *Night hours*, please record time worked between 12:00 AM (midnight) and 6:00 AM under in and out times. Any amount of time worked up to two hours between 12:00 AM (midnight) and 6:00 AM will be paid as two hours of *Night Hours*. Please split *Day/Eve Hours* and *Night hours* correctly. If a PCA works from Saturday 10:00 PM through Sunday Morning at 2:00 AM, then the two hours from 10:00 PM to 12:00 AM (midnight) are *Day/Eve Hours* on Saturday and the two hours from 12:00 AM (midnight) to 2:00 AM are *Night hours* on Sunday (You will be starting a new week.).

6.) **Marking Instructions:** For optimum accuracy, please

- Write in **BLACK PEN ONLY**.
- Write numbers as large and legible as possible without touching sides of boxes.
- Mark circles by filling them in like this: ● (Do not check or circle × them.)
- When recording hours and minutes in the Tot. Day/Eve Hours column, be sure to use hours plus minutes in 15 minute increments. E.g. 1:00PM to 2:30PM is 1:30, (not 1 ½ or 1.5.)
- If you have any questions, please call FI or your skills trainer for clarification before submitting the timesheet.

Payroll Period

From Sunday

/

/

Through Saturday

/

/

STAVROS FISCAL INTERMEDIARY SERVICES

P.O BOX 2130, Amherst, MA 01004-2130

Tel: (413) 256-6692, (800) 442-1185

Fax: (888) 773-4281, (413)256-3849

29595

Employer Information

PCA Information

Number:

Name

SSN: Last 4 Digits Only

Name

USE FOR PCA PAID TIME OFF ONLY*USO PARA PCA TIEMPO LIBRE PAGADO SOLAMENTE

Please record the hours your PCA was scheduled to work but has requested paid time * Favor de escribir las horas que su PCA estaba designado para trabajar, pero ha solicitado tiempo libre pagado.

Week #1	Scheduled Time In				Scheduled Time Out				Tot. Day/Eve Hours 6 AM to Midnight				Tot. Night Hours				Week #2	Scheduled Time In				Scheduled Time Out				Tot. Day/Eve Hours 6 AM to Midnight				Tot. Night Hours			
	Hour	MIN.			Hour	MIN.			Hour	MIN.			Hour	MIN.				In Hour	MIN.			In Hour	MIN.			Hour	MIN.			Hour	MIN.		
Sun.			.														Sun.			.													
Mon.			.														Mon.			.													
Tue.			.														Tue.			.													
Wed.			.														Wed.			.													
Thu.			.														Thu.			.													
Fri.			.														Fri.			.													
Sat.			.														Sat.			.													
Total Week 1																	Total Week 2																

By signing below, I certify under pains of perjury that I was scheduled to receive MassHealth PCA services from the PCA during the Paid Time Off time taken, as indicated on this activity form and I am not enrolled in Adult Foster Care or Group Adult Foster Care.

By signing below, I certify under pains of perjury that I was scheduled to provide MassHealth PCA services to the consumer during the Paid Time Off times taken, as indicated on this activity form. I understand I must have accrued Paid Time Off in order to receive Paid Time Off.

Employer/Surrogate's signature

Date

PCA's Signature

Date

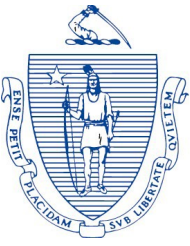
INSTRUCTIONS FOR PAID TIME OFF ACTIVITY FORM TIMESHEET – A SEPARATE TIMESHEET MUST BE COMPLETED BY EACH PCA FOR EACH CONSUMER

PLEASE NOTE:

- MassHealth regulations state that the consumer has a responsibility to utilize PCA services in accordance with the number of Day/Evening hours per week and Night hours per night authorized by MassHealth.
- MassHealth PCA regulations require the PCAs to have their PCA payments direct deposited into their bank or debit card account.
- MassHealth prohibits payment to any PCA whose name appears on the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) **ONLY USE THIS FORM TO REPORT PCA PAID TIME OFF!**

1. **Please mail, fax or deliver this signed timesheet by 12:00 P.M. on the Monday** after the biweekly cycle ends to ensure timely payment. Incomplete or illegible timesheets or timesheets not signed by both employer/surrogate and the PCA will be returned. Please *do not send the timesheet twice*. Be sure to keep a copy of the timesheet for the employer's records.
2. **Record the payroll period dates.** The payroll period runs for 2 weeks. Each week starts on Sunday and runs through Saturday. Please check the payroll calendar for your schedule.
3. **Record the Employer and PCA information.** On the top left side of the timesheet, write the employer number (4 digits) and name. On the top right side, write the last four digits of the PCA's social security number and name. A timesheet missing any of this information may not be processed and may be returned.
4. **Record the PTO time.** PTO time ***MUST reflect the scheduled time the PCA was to work***. PTO time must be reported in 15-minute increments on the Paid Time Off Activity Form Timesheet or the Fiscal Intermediary will round the time up to the next 15-minute increment. Please complete the timesheet indicating the PTO time taken on each day, making sure to put in and out times (representing the start and end of the PTO).
 - There are 2 lines of boxes per day to record the PTO time that the PCA was scheduled to work, with circles to record AM or PM. The time the PCA was scheduled to start, "Time In" should be recorded in hours and minutes and the circle for AM or PM should be filled in completely. Next, the time that PCA was scheduled to leave, "Time Out" should be recorded in hours and minutes and the circle for AM or PM should be filled in. Then, the total time for that shift that the PCA was scheduled to work should be recorded in hours and minutes. For example, 8:00 AM to 10:15 AM equals a total time of 2:15.
 - If the PCA was scheduled to come back and work more hours later the same day, but took PTO, that information should be recorded in the second row in the same day.
 - If your PCA was scheduled to work more than two shifts on the same day, a separate PCA Paid Time Off Activity Form Timesheet is necessary. (Remember to fill out all the required information again.)
5. **Night Time PTO.** You must have authorization from MassHealth for Night hours for your PCA to take PTO during Night hours (time between midnight and 6:00 AM). If you are approved for Night hours, record the time the PCA was scheduled to work between 12:00 AM and 6:00 AM, under in and out times. Time will be paid in 15-minute increments. Please split Day and Night hours correctly. If the PCA was scheduled to work from Saturday 10:00 PM to Sunday 2:00 AM, then the two hours from 10:00 PM to 12:00 AM (midnight) are Day hours on Saturday and the two hours from 12:00 AM to 2:00 AM are Night hours on Sunday. (You will be starting a new week.)
6. **Marking Instructions.** For optimum accuracy, please:
 - Write in BLACK PEN ONLY
 - Write numbers as large and legible as possible without touching sides of boxes.
 - Mark circles by filling them in completely. Do not check or circle them.
 - When recording hours or minutes in the Tot. Day/Eve Hours column, be sure to use hours plus minutes in 15-minute increments. For example, 1:00 PM to 2:30 PM is 1:30 not 1 ½ or 1.5.

If you have any questions, please call FI or your skills trainer for clarification before submitting the timesheet.



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

Tel.: (617) 573-1600
Fax: (617) 573-1891
www.mass.gov/eohhs

To: All Consumers in the PCA Program
From: Whitney Moyer, Chief, Office of Long-Term Services and Supports
Date: July 29, 2019
Re: Collective Bargaining Changes

Several changes to the Personal Care Assistance (PCA) Program recently went into effect or will soon go into effect. The purpose of this memo is to notify you of these important changes and to explain how they affect you and your PCAs.

1. Effective July 1, 2019, the PCA gross wage rate increased to \$15.40 per hour.
2. Effective July 1, 2019:
 - a. All PCA accrued sick time was converted to Paid Time Off (PTO);
 - b. PCAs may accrue up to 50 hours of PTO; and
 - c. PCAs leaving employment after July 1, 2019 from all PCA Program consumers are eligible for a pay-out of unused, accrued PTO.Details regarding PTO can be found in the attached PCA Earned Paid Time Off document.
3. Effective September 1, 2019, consumer-employers and PCAs will be able to access PCA pay advice information electronically on your Fiscal Intermediary's website.
4. Paystub information will default to electronic access; however, PCAs who wish to opt out of this option may receive paystub information via standard mail. Consumers will no longer receive paystub forms via standard mail; however, they will continue to receive a payroll register and cover sheet via standard mail. MassHealth OLTSS will provide the effective date of this change once it is finalized.
5. PCA New Hire Orientation updates effective September 1, 2019:
 - a. A PCA must complete New Hire Orientation within 9 months of the start of PCA employment or will be subject to a \$1.00 per hour payroll deduction until the PCA completes orientation;
 - b. Consumer-employers may determine the method for New Hire Orientation (consumer-taught or group session) within the first 3 months of a PCA's employment;
 - c. PCAs who have not completed New Hire Orientation within the first 3 months of employment must complete group New Hire Orientation within the remaining 4-9 months; and
 - d. PCAs will not be refunded New Hire Orientation sanctions.

PLEASE SHARE THIS IMPORTANT INFORMATION WITH YOUR PCAS

PERSONAL CARE ATTENDANT EARNED PAID TIME OFF

Effective July 1, 2019, Personal Care Attendants (PCAs) shall be eligible for earned Paid Time Off (PTO). Formerly, PCAs were eligible for earned sick time. As of July 1, 2019, all earned sick time will convert to PTO and PCAs shall only be eligible for earned PTO.

Used PTO must be reported on a separate timesheet: the PCA Paid Time Off Activity Form Time Sheet.

Your employer, the MassHealth Member, will obtain PCA Paid Time Off Activity Forms from their Fiscal Intermediary. Any PTO reported on a Regular Activity Form Time Sheet will not be processed for payment.

Please familiarize yourself with the following important information about PTO.

Important Information about Paid Time Off:

- PCAs will earn 1 hour of PTO for every 30 hours worked. PCAs can accrue up to 50 hours of PTO. For purposes of PTO, a year is defined as the state fiscal year (July 1- June 30). The accrual is determined by adding all the hours worked as a PCA across all consumer employers in the MassHealth PCA Program.
- PCAs may not accrue more than 50 hours of PTO. However, if a PCA uses PTO, the PCA may continue to accrue up to 50 hours of PTO. For example, if a PCA earned 50 hours of PTO and in the 10th month of the year took 20 hours of PTO, the PCA would have a balance of 30 hours of PTO. That PCA could continue to earn additional PTO up to the maximum amount of 50 hours PTO.
- PCAs may carry over up to 50 hours of unused earned PTO to the next year. However, a PCA may never have more than 50 hours of unused earned PTO so the PCA must use PTO to be able to start accruing again.
- All PCAs who work enough hours must be allowed to accrue 50 hours per year of earned PTO.
- PCAs begin accruing PTO from their first date of actual work.
- A PCA can begin utilizing earned PTO 90 days after the PCA started working for a consumer.
- PTO can be used for any reason that the PCA cannot or chooses not to work scheduled time. Reasons may include vacation, personal time, sick time, domestic violence or member unavailability.
- It is the PCA's responsibility to use PTO in amounts consistent with their regular schedule. For example, if a PCA typically works 5 hours a day 3 days a week, he or she should use PTO consistent with that schedule. That PCA should not, for example, take 8 hours of PTO for 5 days in a week.

- PTO cannot be taken at the same time/same hours that the PCA is providing personal care to another consumer in the PCA program (i.e., a PCA cannot submit an activity form for providing PCA services seeking regular pay and also submit a PTO activity form seeking pay for using earned PTO for the same hours).
- PCAs are entitled to use earned PTO in 15-minute intervals. The shortest time period for which a PCA may use earned PTO is 15 minutes.
- PTO will not count toward the calculation of overtime or other premium rates. However, a PCA who works more than 40 hours in a given week can receive overtime pay in the same week that a PCA uses PTO. For example, if a PCA typically worked 50 hours in a week and took 5 hours of PTO, that PCA would be paid for 45 hours of regular time, 5 hours of overtime premium and 5 hours of PTO.
- PCAs should submit a Paid Time Off Activity Form for each consumer from whom they are requesting PTO. For example, if a PCA works for 2 employers on Monday and would like to take Monday off, the PCA should submit two Paid Time Off Activity Forms. The Paid Time Off Activity Forms should reflect the regularly scheduled hours for which the PCA is taking PTO. The PCA should not submit Paid Time Off Activity Forms for different consumers with overlapping PTO reported.
- Unused accrued PTO will be paid out to PCAs at the end of employment, regardless of whether the PCA left voluntarily or involuntarily.
- A PCA must end employment with all consumers to be eligible for payment of unused accrued PTO.
- A PCA must work for a PCA Consumer, and an activity form must be submitted, for dates of services on or after July 1, 2019, for a PCA to be eligible for payout for any remaining PTO at the end of employment as a PCA. In addition, the Termination Form must be submitted within 1 year of the last date worked to be eligible for payout.
- A Termination Form will initiate the pay-out of unused accrued PTO if the PCA is leaving all employment in the PCA program. A Termination Form must be submitted to the Fiscal Intermediary immediately after a PCA's employment ends. The Termination Form is required regardless of the reason for the end of employment. It is preferred to have both the PCA and the consumer employer sign the Termination Form; however, the Fiscal Intermediary will accept a Termination Form submitted and signed by either the PCA or the consumer employer. If the PCA signs the form, the PCA will attest on the form if he or she is leaving all employment in the PCA program or if he or she is employed by one or more other consumers.
- The PCA and consumer will be asked to attest as to the Date of Separation from employment on the Termination Form. The PCA will be paid out at the wage rate effective as of the Date of Separation. The Date of Separation is defined as the date that the consumer employer and the PCA ended their employment relationship. If the Date of Separation is unknown, please use the last date that the PCA worked for the consumer employer.

- Payout of unused accrued PTO will be issued by the Fiscal Intermediary with the next scheduled payroll after receiving an accurately completed Termination Form.
- **PCAs must make a good faith effort to provide reasonable notice to the consumer employer of the intent to use PTO in advance of the use of earned PTO.** Reasonable notice may include compliance with the consumers' reasonable notification policy and procedure that the PCA customarily uses to communicate with the consumer for absences or requesting leave. If the consumer does not have an existing policy and procedure for providing reasonable notice, the consumer must establish such a policy or procedure, preferably in writing. The policy and procedure should enable the PCA to effectively provide reasonable notice in a way that can be documented.
- A PCA can view his or her unused accrued Paid Time Off balance at the iSolve web portal at <https://www.OnlineEmployer.com/feapca>. Should PCAs or consumer employers have questions regarding PTO, they may contact the Fiscal Intermediary that issues the PCA's payment.

C: PAYROLL SCHEDULE

WEEK 1 ~ 2019

PAY PERIOD	DATE DUE AT STAVROS
DECEMBER 30, 2018 ~ JANUARY 12, 2019	Monday, January 14, 2019
JANUARY 13 ~ JANUARY 26	Monday, January 28, 2019
JANUARY 27 ~ FEBRUARY 9	Monday, February 11, 2019
FEBRUARY 10 ~ FEBRUARY 23	Monday, February 25, 2019
FEBRUARY 24 ~ MARCH 9	Monday, March 11, 2019
MARCH 10 ~ MARCH 23	Monday, March 25, 2019
MARCH 24 ~ APRIL 6	Monday, April 8, 2019
APRIL 7 ~ APRIL 20	Monday, April 22, 2019
APRIL 21 ~ MAY 4	Monday, May 6, 2019
MAY 5 ~ MAY 18	Monday, May 20, 2019
MAY 19 ~ JUNE 1	Monday, June 3, 2019
JUNE 2 ~ JUNE 15	Monday, June 17, 2019
JUNE 16 ~ JUNE 29	Monday, July 1, 2019
JUNE 30 ~ JULY 13	Monday, July 15, 2019
JULY 14 ~ JULY 27	Monday, July 29, 2019
JULY 28 ~ AUGUST 10	Monday, August 12, 2019
AUGUST 11 ~ AUGUST 24	Monday, August 26, 2019
AUGUST 25 ~ SEPTEMBER 7	Monday, September 9, 2019
SEPTEMBER 8 ~ SEPTEMBER 21	Monday, September 23, 2019
SEPTEMBER 22 ~ OCTOBER 5	Monday, October 7, 2019
OCTOBER 6 ~ OCTOBER 19	Monday, October 21, 2019
OCTOBER 20 ~ NOVEMBER 2	Monday, November 4, 2019
NOVEMBER 3 ~ NOVEMBER 16	Monday, November 18, 2019
NOVEMBER 17 ~ NOVEMBER 30	Monday, December 2, 2019
DECEMBER 1 ~ DECEMBER 14	Monday, December 16, 2019
DECEMBER 15 ~ DECEMBER 28	Monday, December 30, 2019
DECEMBER 29, 2019 ~ JANUARY 11, 2020	Monday, January 13, 2020

STAVROS FISCAL INTERMEDIARY SERVICES 2019 PAYROLL SCHEDULE
TO AVOID DELAY IN PAYMENT, IT'S VERY IMPORTANT THAT YOUR TIMESHEET ARRIVES NO LATER THAN THE DUE DATE LISTED TO THE RIGHT OF THE PAY PERIOD DATES. FAX OR MAIL YOUR TIMESHEETS TO STAVROS.
OUR FAX NUMBERS ARE (413) 256-3849 OR 1-800-773-4281.
OUR ADDRESS IS: STAVROS CIL, PO BOX 2130, AMHERST, MA 01004.
YOU MAY ALSO SCAN AND EMAIL THE TIMESHEETS TO:
FITIMESHEETS@STAVROS.ORG

BE SURE TO SIGN UP FOR DIRECT DEPOSIT!!

FISCAL OFFICE HOLIDAY CLOSING

TUESDAY, JANUARY 1-NEW YEAR'S DAY
 MONDAY, JANUARY 21-MARTIN LUTHER KING, JR.
 MONDAY, FEBRUARY 18-PRESIDENT'S DAY
 MONDAY, APRIL 15-PATRIOTS' DAY
 MONDAY, MAY 27-MEMORIAL DAY
 THURSDAY, JULY 4-INDEPENDENCE DAY
 MONDAY, SEPTEMBER 2-LABOR DAY
 MONDAY, OCTOBER 14-COLUMBUS DAY
 MONDAY, NOVEMBER 11-VETERANS DAY
 THURSDAY & FRIDAY, NOVEMBER 28 & 29
 THANKSGIVING BREAK
 WEDNESDAY, DECEMBER 25-CHRISTMAS DAY

MASSHEALTH APPROVED HOLIDAYS

NEW YEAR'S DAY. JULY 4TH.
THANKSGIVING DAY AND
CHRISTMAS DAY

**TO DOWNLOAD CALENDARS,
 NEW HIRE FORMS, TIMESHEETS
 AND OTHER FISCAL FORMS~**

PLEASE VISIT:

WWW.STAVROSFI.ORG

2019

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WEEK 2 ~ 2019

PAY PERIOD	DATE DUE AT STAVROS
DECEMBER 23 2018 ~ JANUARY 5, 2019	Monday, January 7, 2019
JANUARY 6 ~ JANUARY 19	Monday, January 21, 2019
JANUARY 20 ~ FEBRUARY 2	Monday, February 4, 2019
FEBRUARY 3 ~ FEBRUARY 16	Monday, February 18, 2019
FEBRUARY 17 ~ MARCH 2	Monday, March 4, 2019
MARCH 3 ~ MARCH 16	Monday, March 18, 2019
MARCH 17 ~ MARCH 30	Monday, April 1, 2019
MARCH 31 ~ APRIL 13	Monday, April 15, 2019
APRIL 14 ~ APRIL 27	Monday, April 29, 2019
APRIL 28 ~ MAY 11	Monday, May 13, 2019
MAY 12 ~ MAY 25	Monday, May 27, 2019
MAY 26 ~ JUNE 8	Monday, June 10, 2019
JUNE 9 ~ JUNE 22	Monday, June 24, 2019
JUNE 23 ~ JULY 6	Monday, July 8, 2019
JULY 7 ~ JULY 20	Monday, July 22, 2019
JULY 21 ~ AUGUST 3	Monday, August 5, 2019
AUGUST 4 ~ AUGUST 17	Monday, August 19, 2019
AUGUST 18 ~ AUGUST 31	Monday, September 2, 2019
SEPTEMBER 1 ~ SEPTEMBER 14	Monday, September 16, 2019
SEPTEMBER 15 ~ SEPTEMBER 28	Monday, September 30, 2019
SEPTEMBER 29 ~ OCTOBER 12	Monday, October 14, 2019
OCTOBER 13 ~ OCTOBER 26	Monday, October 28, 2019
OCTOBER 27 ~ NOVEMBER 9	Monday, November 11, 2019
NOVEMBER 10 ~ NOVEMBER 23	Monday, November 25, 2019
NOVEMBER 24 ~ DECEMBER 7	Monday, December 9, 2019
DECEMBER 8 ~ DECEMBER 21	Monday, December 23, 2019
DECEMBER 22, 2019 ~ JANUARY 4, 2020	Monday, January 6, 2020

STAVROS FISCAL INTERMEDIARY SERVICES 2019 PAYROLL SCHEDULE
TO AVOID DELAY IN PAYMENT, IT'S VERY IMPORTANT THAT YOUR TIMESHEET ARRIVES NO LATER THAN THE DUE DATE LISTED TO THE RIGHT OF THE PAY PERIOD DATES. FAX OR MAIL YOUR TIMESHEETS TO STAVROS. OUR FAX NUMBERS ARE (413) 256-3849 OR 1-800-773-4281. OUR ADDRESS IS: STAVROS CIL, PO BOX 2130, AMHERST, MA 01004. YOU MAY ALSO SCAN AND EMAIL THE TIMESHEETS TO: FITIMESHEETS@STAVROS.ORG
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FISCAL OFFICE HOLIDAY CLOSING

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 MONDAY, JANUARY 21-MARTIN LUTHER KING, JR.
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 MONDAY, MAY 27-MEMORIAL DAY
 THURSDAY, JULY 4-INDEPENDENCE DAY
 MONDAY, SEPTEMBER 2-LABOR DAY
 MONDAY, OCTOBER 14-COLUMBUS DAY
 MONDAY, NOVEMBER 11-VETERANS DAY
 THURSDAY & FRIDAY, NOVEMBER 28 & 29
 THANKSGIVING BREAK
 WEDNESDAY, DECEMBER 25-CHRISTMAS DAY

MASSHEALTH APPROVED HOLIDAYS

NEW YEAR'S DAY. JULY 4TH. THANKSGIVING DAY AND CHRISTMAS DAY

TO DOWNLOAD CALENDARS, NEW HIRE FORMS, TIMESHEETS AND OTHER FISCAL FORMS~

PLEASE VISIT:

WWW.STAVROSFI.ORG

2019

January						
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Where to send the Personal Care Attendant Activity Forms:

You can mail them to:
Stavros Fiscal Intermediary Services
PO Box 2130
Amherst, MA. 01004-2130

You can FAX them to:
888-773-4281
413-256-3849
413.256-3491

If you need PCA activity forms or PCA employee tax forms, please contact the Stavros Fiscal Intermediary or your Skills Trainer.

Reminders:

- If activity forms are faxed, *do not mail them!*
- Always mail or fax all PCA activity forms for one pay period together.
- If a payroll issue arises, please contact the Stavros FI at 1-800-442-1185.
- If you have any questions on how to properly use your PCA hours, please contact your Skills Trainer.

D: DISTRIBUTION OF ATTENDANT'S PAYROLL CHECK

- **PAYROLL WILL BE PAID BI-WEEKLY. A SCHEDULE IS ENCLOSED WITH THE DATES ACTIVITY FORMS ARE DUE AND THE ASSOCIATED CHECK DATES.**
 - **Payroll check-** Payroll checks and a payroll report will be mailed to each consumer to distribute to his/her Attendant.
 - **Direct Deposit-** a direct deposit form (for the Attendant's payroll) with the required information is available upon request, and will be in effect within 2 to 4 weeks after receipt by the Fiscal Intermediary.
 - Upon request, with at least 2 to 4 weeks' notice, the Fiscal Intermediary will make available for pick-up to the consumer (only with picture identification) the payroll check for his/her Attendant.

E: HOLIDAY PAY

MassHealth has approved four (4) holidays at time and a half: *New Year's Day, July 4th, Thanksgiving Day and Christmas Day*. Activity time performed between the *hours of 6:00a.m. And midnight* are paid at the holiday rate currently established by the Division of Health Care Finance & Policy. The FI cannot pay PCA time and a half for Night Time Attendant hours on these holidays.

F: Paid Time Off (PTO)

Effective July 1, 2019 all PCA accrued sick time was converted to Paid Time Off (PTO). PCAs may accrue up to 50 hours of PTO; and PCAs leaving Employment after July 1, 2019 from all PCA Program consumers are eligible for a pay-out of unused, accrued PTO.

Effective September 1, 2019, consumer-employers and PCAs will be able to access PCA pay advice information electronically on your Fiscal Intermediary's website. Details regarding PTO can be found in the attached PCA Earned Paid Time Off document.

If your PCA has questions regarding their accrued sick time they can contact the Fiscal Intermediary or visit the web portal at <https://www.onlineemployer.com/feapca>. It is important to ensure that sick time is being utilized in accordance with the law and is not being submitted fraudulently.

PCAs begin accruing time from their first date of actual work and will earn 1 hour of sick time for every 30 hours worked. PCAs can accrue up to 40 hours of sick time which includes any hours rolled over from the previous year. PCAs can use up to 40 hours of sick time in a calendar year and can begin utilizing their accrued sick time 90 days **after** the PCA started working for the consumer.

Under the law, a PCA can use sick time for the following reasons:

- To care for the PCAs child, spouse, parent or parent of a spouse.
- To care for the PCAs own physical or mental illness, injury or medical condition
- To attend routine medical appointments
- To address the psychological, physical or legal effects of domestic violence.

PCAs must make a good faith effort to provide reasonable notice of the need in advance of the use of sick time.

If a PCA is absent from work for more than 24 consecutively scheduled work hours, you may require a doctor's note or other certification as detailed in the regulations. If a PCA does not have a medical provider the PCA may sign a written statement that the earned sick time was needed for a reason covered by the law.

If the PCA is absent from work due to domestic violence you must accept any of the following as evidence for the use of sick time: a restraining order issued by the court, a police record documenting the abuse, medical documentation of the abuse, a statement from a professional who has assisted the individual in addressing the effects of the abuse, a document showing the abuser has been convicted of a violent crime against a family or household member, or a signed written statement from the individual that the abuse took place. You **cannot require** further information about the PCAs medical condition or details of the domestic violence.

Fraudulent use or abuse of earned sick time by you or your PCA, by engaging in activity that is not consistent with allowable purposes for leave must be reported to the Bureau of Special Investigations at 617-727-8638. For more information on Earned Sick Time you may view regulations at www.mass.gov/ago/earnedsicktime.

G: NIGHT TIME ATTENDANT SERVICES (midnight to 6:00a.m.)

If MassHealth approves PCA services for you at night (this is a separate approval that has no bearing on your daytime hours), it will pay your PCA two (2) hours of time for providing direct service with ADLs at night, whether the PCA works 50 minutes or 100 minutes (any amount of time up to two hours). Nighttime hours are paid from a separate account and can only be worked **by one PCA per night**.

H: OVERTIME

MassHealth has implemented an Overtime Management policy limiting the total number of hours worked by a PCA to 50 hours per week. The number of hours one PCA can work providing MassHealth PCA services is limited to 50 hours each week, unless you have received an overtime approval from MassHealth to schedule your PCA to work more than 50 hours each week. The 50 hour limit applies if your PCA works for you, or for you and other PCA consumers.

You must discuss your hours with your PCA and schedule your PCA for no more than 50 hours each week, taking into account any hours that your PCA is working for other PCA consumers. For example if you hire a PCA who is already working 30 hours per week for another PCA consumer then the PCA can only work up to 20 hours per week for you, unless you obtain an overtime approval from MassHealth.

You must ensure you do not schedule your PCA to work more hours than you are approved.

All PCA consumers are required to have a backup list of PCAs. This is to ensure you have adequate coverage in case your scheduled PCA cannot work their scheduled time.

If you have an individual PCA that works more than 50 hours per week, you will need to apply to receive an overtime approval from MassHealth. There are two approval types- *Temporary* and *Continuity of Care*, these are described below. If you have questions on what type of overtime approval to request, your Skills Trainer will assist you in explaining and requesting the correct time-limited overtime approval.

Note: If your PCA works more than 50 hours per week for more than one member, even if s/he does not work more than 50 hours a week for you, you are still required to submit and Overtime Request Form requesting your PCA be approved to work more than 50 hours in one week.

CLW and your Skills Trainer will assist you with the Overtime Policy:

- Provide information and assist you in understanding the new Overtime Management policy and consequences for non-compliance.
- Provide you with the Overtime Request Form and assist you with completing it.
- Submit the Overtime Request Form to MassHealth within one business day of receipt.
- Notify you of MassHealth's decision regarding your overtime approval request within one business day and notify your SCO or One Care provider, if applicable.
- Work with you to identify, hire and appropriately schedule PCAs.
- Provide information about the appeal process through the MassHealth Board of Hearings if your overtime request is denied.
- Notify you when your overtime approval is about to expire, so that you can request a new overtime approval, if needed. Overtime re-approval requests must be submitted 15 days prior to the expiration date of your current approval.
- Assist you in understanding letters or information you receive on the Overtime Management policy.

Types of Overtime Approvals

Temporary

- You have a temporary need to schedule a PCA to work overtime hours due to the following reasons:
 - You have planned travel and can only bring one PCA with you.
 - Your PCA is temporary unavailable due to a planned vacation, family or medical leave, or college schedule (winter or summer break)
 - You have a temporary need for additional hours (i.e. after hospitalization)
 - You need time recruit and hire additional PCAs in order to ensure that your care is not interrupted.

- Temporary Approvals will be for up to a 12 week period.
- Additional Temporary Approvals may be requested if there is a continued need.

Continuity of Care

- Continuity of Care Approvals are longer term overtime approvals and based on your medical needs or co-habitation status with your PCA. The overtime approval will align with your prior approval for PCA services.
- If you are approved for a Continuity of Care Approval your PCA can work up to a total of 66 hours per week. This includes hours worked for other MassHealth PCA consumers. **If you need your PCA to work more than 66 hours per week you must apply for a Temporary Approval.**
- You may request a Continuity of Care Overtime Approval for the following reasons:
 - Live-In PCA: If you are authorized between 50 and 66 hours per week (including your night time hours) and you live with your PCA who provides all of your care.
 - Complex Medical Needs: Your complex care needs requires specialized skills of your experienced PCA.
 - You have communication barriers that require the specialized skills of your experience PCA.
 - You have specialized medical conditions that necessitate fewer PCAs. Examples include; a compromised immune system, significant cognitive impairments or behaviors that impact safety, etc.
 - You receive Hospice care.
 - Your PCA has worked for you for more than 5 years.

Emergency Overtime

- If your regularly scheduled PCA is unexpectedly not available and the only PCA available will need to work more than 50 hours in one week, you must contact your Personal Care Management Agency immediately to request overtime pay for that PCA. If it is the weekend, evening or holiday, you can leave a message on the PCM agency's answering machine.
- CLW will contact the FI to obtain timesheets and will contact MassHealth to request approval of overtime.

- Emergency Overtime Approvals are for unforeseen events and are approved for short periods of time, such as one week.

The following pages include:

- A copy of the consumer letter that MassHealth sent to current PCA consumers in November 2016.
- The Overtime Approval Request Form and Instructions
- Temporary and Continuity of Care Approval Criteria
- Frequently Asked Questions

Contact your Skills Trainer if you have questions about the Overtime Policy, need assistance in completing the Overtime Approval Request Form, or need assistance in recruiting and hiring additional PCAs.

MassHealth PCA Prior Authorization Overtime Form

[Clear](#)

Section 1: General Information

Personal Care Management (PCM) Agency Information:

PCM Agency Name:	The Center for Living & Working		
PCM MassHealth Provider Number:	110030968C		
Requesting Contact <i>(Name, Phone, Fax)</i>			(508) 755-1072
PA Review Type <i>If expedited, explain the necessity</i>			
<input type="checkbox"/> Standard <input type="checkbox"/> Expedited			

Consumer Information:

Consumer Name:	Date of Birth:
MassHealth ID Number:	
Consumer Fiscal Intermediary ID Number (if known):	
Consumer Telephone Number:	
Consumer Address:	
Surrogate Name (if applicable):	Surrogate Phone (if applicable):

Personal Care Attendant Provider Information:

PCA Name:	PCA Unique Identifier Number:
PCA Address:	
PCA Phone Number:	

Request Authorization Type:

Please select the reason below that best explains why the PCA must work in excess of 50 hours per week (select only one). An individual PCA is limited to working no greater than 66 hours per week, unless the consumer has obtained a Temporary Authorization.

<input type="checkbox"/> Temporary Authorization (Go to Section A)	<input type="checkbox"/> Continuity of Care Authorization (Go to Section B)
--	---

[Print](#)[Clear](#)

Consumer Name: _____

SECTION A: TEMPORARY AUTHORIZATION

Temporary Authorization requests will be approved when one or more of the following circumstances are present:

- ☐ I need more time to hire additional PCAs (please check one).
- ☐ Placed multiple ads/used multiple resources for seeking PCAs, but received no responses for PCAs that could appropriately fulfill my personal care needs, including registering on a PCA directory website and is using that website to try to recruit PCAs
 - ☐ Interviewed multiple PCAs but no PCA would accept the position
 - ☐ The PCA I hired did not remain in my employment because PCA could not attain basic knowledge to safely carry out the PCA assigned tasks
 - ☐ The PCA left employment suddenly
 - ☐ My PCA works more than 66 hours per week and I need time to hire additional PCAs
- ☐ I will be traveling and it is not possible to bring more than one PCA
- ☐ One or more of my PCA's needs to take a short-term leave in their schedule for one of the following reasons (please check one):
- ☐ In school; temporarily absent due to school
 - ☐ Family leave
 - ☐ Maternity leave
 - ☐ Sick leave
- ☐ I have a temporary need for an individual PCA to work in excess of 50 hours per week that is not listed above. Please describe the circumstance:

Consumer Name: _____

SECTION B: CONTINUITY OF CARE AUTHORIZATION

Continuity of Care Authorization requests will be approved for your Prior Authorization period when one or more of the below circumstances are present:

☐ I have complex medical needs that require the specialized skills of a specific PCA. Please describe the circumstance:

☐ I have another circumstance that makes it difficult for me to hire additional PCAs. Please describe this circumstance:

Please explain the progress you are making towards hiring additional PCAs and meeting the scheduling requirement, if applicable (must include registration on the Rewarding Work website):

☐ I am receiving hospice care

☐ My PCA has worked with me for 5 or more years

☐ My PCA lives with me, and is the only PCA working for me and I am approved for 50 to up to 66 hours of PCA services per week.

In order to qualify for this exception, the consumer must present documentation proving that the consumer and PCA live together. The required documents must include physical address and not a P.O. Box.

Consumers must include a minimum of two of the following documents. The documents that you include must have the PCA's name and address. (select and attach both to this document)

- ☐ Water bill - no older than three months
- ☐ Electric bill - no older than three months
- ☐ Cable TV bill - no older than three months
- ☐ Phone bill - no older than three months
- ☐ Current homeowner's or renter's insurance certificate
- ☐ Current automobile insurance certificate
- ☐ Vehicle registration title
- ☐ Voter registration card
- ☐ Property tax bill or receipt
- ☐ Residential rental contract (apartment lease or other rental of real property or original and signed verification letter from landlord)
- ☐ Driver's license or state-issued identification
- ☐ Change of address confirmation from U.S. Postal Service
- ☐ Other form or documentation that contains information identifying the PCA's name and residence

Check if both forms of identification are "Other"

Consumer Name: _____

ATTESTATION ORIGINAL SIGNATURES REQUIRED

CONSUMER/SURROGATE

I certify that I have reviewed and confirm that the information contained herein is true and accurate. I understand that falsification, omission, or concealment of any material fact contained herein may result in the determination that I require a surrogate to manage my PCA services. I understand that I may also be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. This documentation will be retained by my PCM Agency in my record and in the event of an audit, the MassHealth agency may at its discretion request any and all medical records of MassHealth Consumers corresponding to, or documenting the services claimed, in accordance with 130 CMR 422.000 and 130 CMR 450.204 and 450.205.

I WILL NOTIFY MY FISCAL INTERMEDIARY IMMEDIATELY IF I HIRE ADDITIONAL PERSONAL CARE ATTENDANTS OR IF MY LIVING CIRCUMSTANCES CHANGE.

Consumer Signature

Date

Surrogate Signature (if applicable)

Date

PERSONAL CARE ATTENDANT

I certify that I have reviewed and confirm that the information contained herein is true and accurate. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. This documentation will be retained by the PCM Agency in the consumer's record and in the event of an audit, the MassHealth agency may at its discretion request any and all medical records of MassHealth consumers corresponding to, or documenting the services claimed, in accordance with 130 CMR 422.000 and 130 CMR 450.204 and 450.205.

PCA Provider Signature

Date

PERSONAL CARE MANAGEMENT AGENCY (TO BE COMPLETED BY THE PCM AGENCY ONLY)

I certify, to the best of my knowledge, that the information on this form is true, accurate, and complete.

PCM Agency Name: _____

PCM Agency Signature

Date

PCM Agency, select one of the following:

Consumer is in: ☐ FFS ☐ SCO ☐ One Care

If SCO or One Care is checked, fill in:

Approved number of hours
per week (day/eve plus night): _____

Approval Start
Date: _____

End Date: _____

Consumer Prior Authorization Number: _____

Consumer Name: _____

MassHealth Personal Care Attendant Program

INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THE OVERTIME REQUEST FORM

INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THIS FORM

You, the consumer or surrogate, if applicable, must fill out this form and make copies of any required documentation. To request assistance in filling out this form, contact your PCM Agency. Submit this form and required documentation to your PCM Agency.

CONSUMER INFORMATION

Fill in your information to include your name, address, phone number, MassHealth ID number, consumer fiscal intermediary ID number (if known), date of birth. If you have a surrogate, include your surrogate's name and phone number.

PERSONAL CARE ATTENDANT INFORMATION

Fill in your PCA's information to include name, address, phone number, and PCA Unique Identifier Number, located on your PCA's Activity Sheet. If you do not know your PCA's Unique Identifier Number, contact your fiscal intermediary.

REQUEST OVERTIME TYPE

Indicate which request type you are seeking. If you are approved to schedule a PCA to work in excess of 10 hours of overtime per week, the number of approved hours will not exceed the amount of your approved prior authorization hours.

PCAs are limited to working no greater than 66 hours per week, unless the Consumer has obtained a Temporary Authorization. Consumers cannot obtain a Continuity of Care Authorization if their PCA works greater than 66 hours per week.

SECTION A: TEMPORARY AUTHORIZATION

You must obtain a Temporary Authorization for your PCA to work more in excess of 10 hours of overtime per week to avoid a disruption in care temporarily while you seek to hire additional PCAs, if applicable.

SECTION B: CONTINUITY OF CARE AUTHORIZATION

Continuity of Care Authorization requests will be approved for your Prior Authorization period when one or more of the listed circumstances is present. Consumers cannot obtain a Continuity of Care Authorization if their PCA works greater than 66 hours per week. If a PCA works greater than 66 hours per week, the Consumer must apply for a Temporary Authorization.

ATTESTATION

CONSUMER/SURROGATE

You and your surrogate, if any, must sign and date the form and must certify that all information contained within the form is true, accurate, and complete.

PERSONAL CARE ATTENDANT

Your PCA must sign and date the form and must certify that all information contained with the form is true, accurate, and complete.

PERSONAL CARE MANAGEMENT AGENCY

The PCM Agency representative must fill in the PCM Agency name, sign and date the form, and certify that the information is true, accurate, and complete to the best of the PCM Agency's knowledge. The PCM Agency must select if the consumer is enrolled in Fee for Service (FFS), Senior Care Options (SCO), or One Care.

If the consumer is enrolled in SCO or One Care, fill in the approved number of hours per week (day/eve plus night) and SCO or One Care approval start and end date

ALL DOCUMENTS MUST BE MAINTAINED IN THE CONSUMER'S CASE RECORD

I: WORKER'S COMPENSATION

Worker's compensation is provided on behalf of the consumer when they start the PCA program and is available to the PCAs of those consumers.

Massachusetts Personal Care Attendant Program Workers Compensation Claims Reporting Procedures

PCAs ARE ELIGIBLE TO RECEIVE WORKERS COMPENSATION INSURANCE BENEFITS IF THEY ARE INJURED WHILE THEY ARE WORKING

CALL ATLANTIC CHARTER INSURANCE COMPANY AND REPORT THE INCIDENT WITHIN **24 HOURS**.

ATLANTIC CHARTER INSURANCE COMPANY
25 New Chardon Street, 6th Floor
Boston, MA 02114-4721

617-488-6500 Main Number
617-488-6501 Fax Number

CALL STAVROS AND REPORT THE INCIDENT TO YOUR FISCAL INTERMEDIARY: 1 -**800-442-1185**

J: UNEMPLOYMENT INSURANCE BENEFITS

You have been given a copy of the form 590A (How to file for Unemployment Benefits). This form is to be given to PCAs at the time of termination by the consumer.

K: PCA TERMINATION FORM/Paid Time Off (PTO) Pay Out Request

You have been given a PCA termination form to be filled out by the consumer upon the termination of a PCA and it is to be sent in with their last Activity Form.

Obtaining UI services by telephone.



It's Easy.

When you call the Unemployment Insurance Tele-Claim Center, you will press a number on your telephone to choose services in English or another language.

Press **1** — to file a new UI claim or to reopen an existing claim.

You will be asked to enter your social security number and the year you were born. **Then you will be transferred to a DUA agent who will help you file your claim.**

Press **0** — for immediate information on the status of your check or claim certification form.

Enter your social security number and the year you were born. You will be able to obtain automated information on the status of your weekly signing form or your UI check. This is the same information available to DUA staff. If there is a problem with your claim, you will be transferred to a DUA agent.

Press **2** — for customer assistance, to resolve a problem, to provide a social security number for a dependent child, or to change your address.

Press **3** — for information on the Unemployment Insurance program, how to file for benefits, and how to obtain job search and retraining assistance.

You can listen to recorded information on the Unemployment Insurance program and obtain the addresses and telephone numbers of the nearest offices that provide reemployment services and information on training opportunities.

This pamphlet includes important information on how to file a claim for Unemployment Insurance benefits.

Эта брошюра содержит важную информацию о том, как подать документы для получения пособия по безработице.

本手冊包括如何建立失業保險福利檔案的重要資訊。

Este panfleto incluye información importante sobre cómo entablar un reclamo por beneficios de Seguro de Desempleo.

Materyèl sa ginyin enfòmasyon ki impòtan o sigè dé ki gan pou fè yon déman pou asirans pou moun ki pap travay yo.

Il presente documento include importante materiale informativo su come presentare domanda circa la riscossione di un premio assicurativo per Disoccupazione.

Tập sách nhỏ này có nhiều tài liệu quan trọng về quyền lợi và trách nhiệm của bạn trong chương trình bảo hiểm cho người thất nghiệp. Hãy nhờ người dịch ra cho bạn.

Este panfleto inclui informação importante sobre como preencher uma reclamação para os benefícios de segurança dos desempregados.

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Commonwealth of Massachusetts

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.

TDD/TTY 1-800-439-2370 - Voice 1-800-439-0183
www.mass.gov/dua

Printed on recycled paper Form 0590-A Rev. 12-08



To Massachusetts Workers:

How to File for Unemployment Insurance Benefits

To Massachusetts Employers:

Under the state's Employment and Training Law, you are required to give a copy of this pamphlet to each of your employees who is separated from work, permanently or temporarily. Please complete the information below:

Employer name (as listed in DUA Quarterly Contribution Report)

DUA	Employer	ID	Number
-----	----------	----	--------

Federal Employer ID Number (optional)

Address

(to which DUA should mail request for separation and wage information)

You have a choice. There are two ways to file

your claim for Unemployment Insurance benefits.

You can call the TeleClaim Center.



Expanded hours:

**Monday to Friday, 8:30 am - 6:30 pm,
Saturday, 8:00 am - 1:30 pm**

Unemployment Insurance services are available by telephone. You can file a new claim for Unemployment Insurance, reopen a current claim, be interviewed if there are issues that affect your eligibility, obtain up-to-date information on the status of your claim and benefit payment check, and resolve problems — all by telephone.

When you call the TeleClaim Center, you will be asked to enter your social security number and the year you were born — using the numbers on a touch-tone telephone. **Then you will be transferred to an agent who will take the information necessary to file your claim.**

You can file your claim in person.



Unemployment Insurance Walk-In services are available at more than 35 sites located conveniently throughout Massachusetts.

Services include assistance with filing a new claim for Unemployment Insurance, reopening a current claim, and resolving problems with your claim.

For the address of the nearest UI Walk-In site, call **617-626-6560**. After hearing the greeting, enter the number **331** on the keypad of a touch tone telephone. When you are asked to do so, enter the first five digits of your zip code. You will be given the address of the Walk-In Center nearest you.

You can also find the addresses of all Walk-In Centers in Massachusetts on the DUA web site at **www.mass.gov/dua**. Select "Find a UI Walk-In Center" under Key Resources.

Filing your claim. Follow these simple steps.

Step 1 - Decide how to file your claim.

Choose to file your claim in person or by calling the TeleClaim Center. Walk-In offices are located in every region of the state. For the address of the nearest office, call **617-626-6560**. After hearing the greeting, enter the number 331 on the keypad of a touch tone telephone. When you are asked to do so, enter the first five digits of your zip code. You will be given the address of the Walk-In Center nearest you. You can also find the addresses of the Walk-In Centers on the DUA web site at **www.mass.gov/dua**. Select "office locator" on the home page.

To file your claim by telephone, call the DUA TeleClaim Center:

**Call the TeleClaim Center at 1-877-626-6800
if you are calling from the following area codes:
351, 413, 508, 774, and 978.**

**Call the TeleClaim Center at 617-626-6800
if you are calling from any other area code.**

When you call the TeleClaim Center, you will press a number on your telephone to choose services in English or another language. From the list of services, Press **4** to file a new UI claim or to reopen an existing claim. You will be asked to enter your social security number and the year you were born. You will be transferred to a DUA agent who will help you file your claim.

Step 2 - Find out when to file.



**For Walk-In Centers, call your local
Career Center for hours.**

**For TeleClaim Centers, Expanded hours:
Monday to Friday, 8:30 am - 6:30 pm,
Saturday, 8:00 am - 1:30 pm**

DUA is committed to providing you with prompt and courteous service. Our goal is to ensure that your claim is filed quickly and efficiently, and that your waiting time is kept to a minimum. If there are callers in queue, you will be given a message about the length of the expected waiting time. If you choose not to wait, you may call back anytime during that week and there will be no effect on the processing of your claim.

The earliest your claim may be filed is during your first full week of unemployment or the first week that you experience a significant reduction in the number of hours you normally work. A delay in filing could affect the amount of your benefits.

Step 3 - Be ready with the following information.



- Your Social Security Number
- The year you were born
- Your residential and mailing address and telephone number
- Whether you have filed an Unemployment Insurance claim in Massachusetts or in any other state during the past 12 months
- Your last day of employment
- The names and addresses of all of the employers you have worked for during the 15 months prior to filing your claim, and the dates you worked for each of these employers. If you are reopening a claim, be ready with the same information for the past 8 weeks.
- The reason that you are no longer working or that your hours have been reduced
- The names, dates of birth and social security numbers for any dependent children, if you are going to apply for dependency allowance
- Your alien registration number if you are not a U.S. citizen

☐ **NOTIFICATION OF TERMINATION OF EMPLOYMENT – PAID TIME OFF (PTO) PAY OUT REQUEST** ☐

EMPLOYER INFORMATION:

SURROGATE INFORMATION:

Employer Number: _____

NAME: _____

NAME: _____

PHONE: _____

PHONE: _____

EMPLOYEE (PCA) INFORMATION:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ LAST 4 DIGITS OF SOCIAL SECURITY#: _____

PHONE: _____

*****EMPLOYEE (PCA) PLEASE CHECK ONE OF THE FOLLOWING-REQUIRED:*****

☐ I NO LONGER WORK FOR ANY CONSUMERS IN THE PCA PROGRAM

☐ I AM WORKING FOR OTHER CONSUMERS IN THE PCA PROGRAM

EMPLOYMENT INFORMATION:

FIRST DAY WORK PERFORMED: _____ LAST DAY WORK PERFORMED: _____

WHY IS THIS EMPLOYEE (PCA) NO LONGER WORKING FOR YOU? (CHECK ONE REASON ONLY)

☐ LACK OF WORK - DO YOU EXPECT TO RECALL THIS EMPLOYEE? _____ YES _____ NO

IF YES, AND THE RECALL DATE IS SCHEDULED, PLEASE ENTER ☐ FAILED TO DATE HERE
MEET PERFORMANCE STANDARDS. NO MISCONDUCT.

☐ DISCHARGED FOR MISCONDUCT ☐ QUIT

☐ LEAVE OF ABSENCE ☐ SUSPENSION

☐ OTHER (PLEASE EXPLAIN) _____

EMPLOYER/SURROGATE SIGNATURE: _____ DATE: _____

EMPLOYEE (PCA) SIGNATURE: _____ DATE: _____

It is the Consumers\Surrogate's responsibility to notify Stavros F.I. promptly if any PCA leaves or is terminated as an employee.

The Massachusetts Wage Act requires employers to pay earned but unused paid time off if a worker leaves or is terminated from employment.

This form can be submitted to Stavros F.I. by either the Consumer Employer\Surrogate or the PCA. It is preferred that the form is signed by both the Consumer Employer\Surrogate and the PCA but Stavros F.I. will accept the form if it is signed by one of the parties.

PLEASE MAIL COMPLETED FORM TO STAVROS F.I., P.O. BOX 2130, AMHERST, MA 01004 OR FAX TO (888)773-4281or (413)256-3849

Section VII:

Rules/Policies/Procedures

Section VII: Rules/Policies/Procedures

A: STATUTORY REQUIREMENTS

1. Posting of Notices

- Several state and federal laws require that employers post notices relating to anti-discrimination laws, wage and hour provisions and job safety and health protection. You should contact state agencies to obtain the most current postings (See Helpful Telephone Numbers.) These notices should be posted in an area that will be visible to your PCAs.

2. Anti-Discrimination Laws

- As previously noted, Massachusetts General Laws, Chapter 151B, provides that employers with six or more employees cannot discriminate in the terms and conditions of their employment on the basis of age, race, gender, sexual preference, national origin, handicap or religion. The Massachusetts Commission Against Discrimination is the state agency given the responsibility of administering the anti-discrimination laws of the Commonwealth. The MCAD's federal counterpart is the Equal Employment Opportunity Commission. If you have any questions regarding either of these two agencies and the laws for which they are responsible, please contact them directly. There may be other anti-discrimination laws that apply to employers with fewer than six employees. Please contact an attorney for further information.

3. Unemployment Benefits

- Your employees will be covered under the State's Unemployment Benefits laws. The Division of Employment and Training administers these laws. Massachusetts General Laws, Chapter 151A, outlines the statutory provisions for claims for unemployment benefits. As an employer, you have obligations under the law to respond to inquiries made by the Division of Employment and Training regarding your current or former employees. Questions regarding unemployment benefits should be directed to the Division of Employment and Training.

4. Insurance

- As an employer, you are obligated to carry worker's compensation insurance. This responsibility may be performed by Stavros. Please contact them to discuss your responsibilities under worker's compensation law.
- You are obligated to maintain a safe and healthy work environment and to report any injuries or illnesses that may arise out of, or during the course of employment. If any of your employees suffer an injury or illness arising out of and/or during the course of their employment, please contact Stavros immediately. The Worker's compensation laws require a timely notification of any injury or illness. Failure to report the injury or illness in a timely manner may prejudice you in defending or disputing a claim. As the employer, you should inform your employees that if they are injured as a result of their employment, you should be notified immediately.
- You may want to consider liability insurance on your property. Please discuss this matter with your insurance agent.
- If you plan to allow the PCA the use of your vehicle during the course of his/her employment, then you should contact your insurance agent to discuss placing his/her name on the policy as a driver of the vehicle.

5. Wage and Hour Laws

- These are covered by the Attorney General's Office. In addition to minimum wage and overtime rules, employees must be given a 30- minute break for every 6 hours worked. This break does not need to be paid and it can take place at the end of a 6- hour shift. No other breaks are legally required. If an employee is required to be on the job site, they must be paid for that time.

6. Other

- These Employment Guidelines cannot possibly include all issues or situations that may occur as a result of your new employer/ employee relationship. CLW recommends that you utilize experienced professionals, including attorneys and accountants, to provide you with the proper guidance and advice necessary for your new employer/employee relationship.

B: OVERUTILIZATION OF PCA HOURS

When MassHealth approves you for services, the time is based on your needs 24 hours per day, 7 days per week. You receive notification from MassHealth and from CLW detailing the number of units (each unit is 15 minutes) you will receive and the dates of service of your Prior Approval. We also send you a copy of the PA-1 form with the average number of hours you should use per week to meet your personal care needs.

If you misuse or overuse this weekly allotment, you will run out of units by the end of your prior authorization. The consequences of this are many.

- If you run out of hours:
 - The Fiscal Intermediary will **not pay** your PCA.
 - You will have to **pay out of pocket** if you continue to use your PCA.
 - You will have to rely on **family or friends** for your care.
 - You may have to go into a **nursing facility** to get your care needs met until your new PA goes into effect.
 - The Division may decide you need a **surrogate** to run your program because you cannot manage it appropriately.

If your condition changes and you require additional hours for your personal care, you should call your Skills Trainer to discuss the situation and request an adjustment to your program.

Note: MassHealth will NOT provide additional hours in the event you overuse and run out of hours.

C: CLIENT ASSISTANCE PROGRAM (CAP)

The Massachusetts Office on Disability Client Assistance Program is available to help you resolve any disagreements with Independent Living Center personnel during your program. Additionally they are available to provide assistance to you during the review process. You may contact CAP at (617) 727-7440 or toll free at (800) 322-2020.

You may discuss a problem, grievance or change in your program at any time by notifying or scheduling an appointment with your Independent Living Center staff or, if you wish, the appropriate supervisor. If you are dissatisfied with the outcome resulting from the above process, you may submit an appeal to the PCM Program Manager or the CLW Registered Nurse within ten working days of the action/inaction for which you are filing. Within five working days of receipt of your appeal, a meeting and/or contact will be held to resolve the stated issue. On rare occasions, a resolution is not obtained in which case you may submit a written and signed appeal to the Executive Director who is the Impartial Hearings Officer. Within five working days of receipt of your written appeal, you will receive an appeal acknowledgment from the Executive Director and within ten working days of receipt of the appeal, a hearing will be scheduled. The Executive Director will render a written decision explaining the issue involved and its resolution within 15 days of the hearing. The Executive Director/Hearing Officer's determination is final.

D: BILLING OF A PCA CHECK FOR A DECEASED CONSUMER

This policy is being formulated to clear up any misunderstandings or miscommunications regarding a deceased consumer's PCA check or time sheet.

PCA payments can only be issued to an executor of the deceased consumer's estate or a duly appointed voluntary administrator of the estate. A Voluntary Administrator Form attested by the Probate Court can be obtained at the Worcester Probate Court, 225 Main Street, Worcester MA. (508-770-0825). A voluntary administrator can be named for estates with values under \$15,000 within 30 days of the death of the consumer. There is an approximate \$50 filing fee cost. A list of assets of the estate will be requested (bank account numbers, car registration, etc.) as well as a listing of living relatives. Also, a certified copy of the death certificate is required and can be obtained at the City Clerk's Office, Rm. 206, City Hall, 455 Main Street, Worcester, MA 01608 (508-799-1126).

Only an executor of the estate or a voluntary administrator of the estate can sign PCA activity forms. Medicaid will not be billed for PCA hours until the above- mentioned legal administrators of the estate sign such time sheets.

PCAs retain the legal right to file in small claims court as a creditor to obtain payment from the estate if an executor or voluntary administrator of the estate is not named.

E: TRANSFER TO ANOTHER PERSONAL CARE AGENCY

A. Consumer transfers that entail a change in Fiscal Intermediary

Please contact your Personal Care Agency for detailed information.

B. When the Fiscal Intermediary Remains the Same

These procedures must be followed when a Consumer requests a transfer from one Personal Care Agency to another and ***the Fiscal Intermediary will not change.***

1. The Consumer requests a transfer from their current Personal Care Agency to new Personal Care Agency.
2. If the transfer involves a change in address for the Consumer, the Personal Care Agency must remind the Consumer to notify the local MassHealth Enrollment Center of the change of address.
3. The Consumer and the Personal Care Agencies must determine the date of transfer.
4. The current Personal Care Agency must forward the following documents to the new Personal Care Agency at least 10 days prior to the date of transfer:
 - a. a cover letter requesting the transfer, including the requested date of the transfer;
 - b. a copy of the current prior authorization (PA);
 - c. a copy of the current Evaluation; and
 - d. appropriate files related to the Consumer
5. The current Personal Care Agency must forward a copy of the above cover letter to:

Division of Medical Assistance
PCA Program Manager
One Ashburton Place, 5th Floor
Boston, MA 02108
6. The new Personal Care Agency must confirm the date of transfer in writing to the current Personal Care Agency and the Consumer, and forward a copy of the confirmation to the Division, the Consumer, and the Fiscal Intermediary.

F: HELPFUL TELEPHONE NUMBERS

Name	Phone
Attorney General's Office: Fair Business Practice	617-727-3465
Department of Industrial Accidents	617-727-4900
Department of Revenue: Customer Service Dept.	800-392-6089
Disability Law Center	800-872-9992
Disabled Persons Protection Commission	800-426-9009
Division of Health Care Finance & Policy	617-988-3100
Division of Employment and Training	617-727-6560
Fair Labor & Business Practice	617-727-3465
Federal Income Tax Bureau (IRS)	617-536-1040 or 800-829-1040
Greater Boston Legal Services	617-371-1234 or 800-323-3205
Legal Assistance Corporation – Worcester	508-752-3718
Massachusetts Commission Against Discrimination	617-727-3990
Massachusetts Office on Disability	617-727-7440 or 800-322-2020
Massachusetts Relay Service	800-439-0183 or TTY 800-439-2370
Social Security Administration	800-772-1213
Western Mass. Legal Services	413-781-7814

G: PT-1 FORM (TRANSPORTATION)

Information about the PT-1 program:

The PT-1 form is essentially a MassHealth Prescription for transportation. It can only be allowed if no other mode of transportation are available, (private or public) and only if door-to-door public transportation is medically necessary. This transportation is available only for medical appointments, not for recreational outings or everyday errands.

To apply you should use the form PT-1 that can be provided to you by your Skills Trainer.

The form needs to be filled out accurately and submitted in a timely manner. No prescription will be honored if it is incomplete. The form needs to be signed by a physician, dentist, nurse practitioner or managed care representative.

Any person who can prove they have an absolute need for this type of transportation can apply.

Who provides transportation?

There are several companies that MassHealth has contracted with to provide this service. A partial list is below. For other companies that may be available you can contact your MassHealth office.

Cape Ann Transportation Authority (CATA)	1-800-830-5191
Franklin Regional Transit Authority (FRTA)	1-413-774-2262
Montachusett Regional Transit Authority (MART)	1-800-922-5636
Berkshire Regional Transit Authority (BRTA)	1-800-292-2782

Some of the companies above may have sub-contracts with other vendors, who can also provide transportation under this program.

Example: Yellow Cab, F&H Transport, and Nipmuc Nation are sub-contracted with RTA.

Some vendors require scheduling in advance; others are available to do same day service. For more information on this, you will need to contact the provider of the services on their individual requirements.

There are some limits on the duration of the services allowed. Providers can prescribe it for up to six (6) months for acute illness, and up to one year for chronic illnesses.

MASSHEALTH PRESCRIPTION FOR TRANSPORTATION FORM

Please indicate the type of request: ☐ New form ☐ Renewal ☐ Increase in visits ☐ Alternate pick-up address

Please print or type all information.

Reset Form

1. MassHealth Member Information

Last name	First name	Date of birth
Member ID	J.	
HOME ADDRESS (The MassHealth member will be transported to and from this address, unless an alternate pick-up address is listed.)		
Street address	Apt. no.	City/Town State Zip
ALTERNATE PICK-UP ADDRESS		
Street address	Apt. no.	City/Town State Zip
MAILING ADDRESS (If different from Home address.)		
Street address	Apt. no.	City/Town State Zip

2. MassHealth Provider Information (Section to be completed by the provider requesting transportation.)

Name of treating provider/facility	Tel. no.	Ext
Street address	Suite no.	City/Town State Zip
MassHealth Provider ID/Service location	NPI	

3. Name and Location of Treating Provider/Facility (Indicate where the MassHealth member will be seen.) Check if same as provider listed in Section 2 ☐

Name of treating provider/facility	Tel. no.	Ext
Street address	City/Town	State Zip
MassHealth Provider ID/Service location	NPI	
Is the treating facility within the member's locality (city or town of residence, or adjacent city or town)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If No, please justify:		

4. Medical Treatment Type

Please list the MassHealth-covered service(s) that the member is receiving at this location.

5. Duration and Frequency of Treatment

How long will the MassHealth member require these services?	<input type="checkbox"/> week(s) <input type="checkbox"/> month(s)
How frequently will the MassHealth member be seen for this service?	<input type="checkbox"/> visit(s) per week <input type="checkbox"/> visit(s) per month

6. Why Transportation Services Are Required

Is there a medical reason why the member (or guardian if accompanying a minor) is unable to use public transportation? ☐ Yes ☐ No

If Yes, please cite specific medical reason:

7. Other Information

Is a wheelchair van needed? ☐ Yes ☐ No

Is an escort accompanying the member for assistance with ambulation or to accompany a minor? ☐ Yes ☐ No

Specify other transportation needs:

8. Provider Signature

Signature:	Date:
Please check appropriate title: <input type="checkbox"/> MD <input type="checkbox"/> DDS <input type="checkbox"/> RNP <input type="checkbox"/> RNC <input type="checkbox"/> Other Please list title:	

Do not write below this line • MassHealth use only

☐ APPROVED. Authorization expires on: Tracking no.:

☐ DENIED. Reason:

MassHealth Authorized Signature: Date:

Instructions for Completing the Prescription for Transportation Form

Section 1 – Enter the member’s name, date of birth, MassHealth member ID, telephone number, and home address, including apartment number, if applicable.

In certain circumstances MassHealth may authorize a member to be picked up at an address other than his/her home address. If the member is to be picked up at an alternate address, enter the alternate address information below the home address information. If there is a mailing address that is different from the home address, enter that below the alternate pick-up address.

Section 2 – Enter the provider’s name, telephone number, address, MassHealth provider ID and location code, and the NPI.

The provider requesting transportation should be a physician, physician’s assistant, nurse midwife, dentist, nurse practitioner, psychologist, or managed care representative, and an active MassHealth provider.

Section 3 – If the provider is also the treating provider, place a check mark in the box labeled “Check if same as provider listed in Section 2.” If the treating provider is different from the provider filling out Section 2, enter that provider’s name, telephone number, address, and, if it is known, their MassHealth provider ID and location code, and the NPI.

If the treatment destination is outside of the member’s locality (city or town of residence, or immediately adjacent communities), indicate why the medical care is unavailable to the member within the member’s locality.

Section 4 – Indicate the specific medical care that will be provided.

Section 5 – Indicate how many weeks or months the member will require transportation, and how frequently the member will be going per week or per month for the service. MassHealth will not authorize more than six months of transportation for an acute illness, or one year of transportation for a chronic illness. For a single visit, enter “1” week, and “1” visit per week.

Section 6 – Indicate if there is a medical reason that the member (or guardian, in accompanying the member) is unable to use public transportation. Provide the specific physical or mental disability that prevents the member from using public transportation.

Section 7 – Indicate if a wheelchair van or an escort is necessary.

Wheelchair van transportation may be provided for non-emergency medical services for members who use a wheelchair or whose severe mobility impairments prevent them from traveling in a vehicle other than a wheelchair van.

Section 8 – The signature of the physician, physician’s assistant, nurse midwife, dentist, nurse practitioner, psychologist, managed care representative, or dental third-party administrator is required to process the PT-1 form. The provider’s signature indicates that all information contained on the form is accurate to the best of his/her knowledge.

For more detailed information about the MassHealth transportation benefit, consult the MassHealth transportation regulations at 130 CMR 407.000. If you have any questions about completing this form, please call the MassHealth Transportation Authorization Unit at 1-800-841-2900.

H: PERSONAL EMERGENCY PREPAREDNESS PLAN



Image: Flu Shot Clinic, Dennis, MA

Personal Emergency Preparedness Plan

Disability Policy Consortium
P.O. Box 77 Boston, MA 02133
866-745-0917 • www.dpcma.org • mail@dpcma.org

Cities and town governments are responsible for planning and responding to a disaster.

Individuals should also prepare themselves, their families, and their caregivers.

Be part of the solution.

PLAN NOW! PLAN TOGETHER!

Community Emergency Plan

Emergency Planning is done for typical Community Hazards

Hurricane

Winter storms

Explosions

Fires

Floods

Who is the Emergency Management Director?

Name:

Office address:

Phone number:

Email:

The community where you live has responsibility for planning and responding to a disaster affecting its residents.

The community needs to:

- be able to communicate with all residents.
- provide shelters to all residents when necessary
- provide transportation to those who need assistance
- store and replenish supplies with fresh food and medication & track expiration dates
- practice their plan

Questions you need answers for before a disaster strikes:

Does the emergency plan address your needs?

Do you know how the community plans to notify you of an approaching disaster?

Do you know what your community evacuation plan is?



Shelters

Where is your neighborhood shelter? Does it meet it meet your minimum accessibility requirements?

Shelter location(s):

Shelter Manager Number to contact (this may be the local emergency manager):

Is there a TTY/TDD available if you need it?

What is the TTY/TDD number?

Is the shelter accessible?

Does the shelter have signs in Braille?

Personal Plans

Individuals also bear a responsibility for preparing themselves and their families/caregivers for disasters.

Individuals should:

- develop a personal, family (guardian) readiness plan that includes evacuation and care of pets
- assemble supplies and needed information for use in disasters when sheltering in place or evacuation is required
- assemble a Go-Bag with essential items, supplies and information
- develop an evacuation plan for home, work and anywhere else you spend any prolonged period of time
- know where the nearest accessible shelters are
- store and replenish supplies with fresh food and medication & track expiration dates
- practice your plan

Support Network: A support network is important. Write your list including work, home, cell numbers as well as addresses and email information.

A recommendation is to have a contact who lives far way and won't be impacted by the disaster for everyone to call.

Name:

Phone Numbers – Home:

Work:

Cell:

Email Address:

Address:

Name:

Phone Numbers – Home:

Work:

Cell:

Email Address:

Address:

Name:

Phone Numbers – Home:

Work:

Cell:

Email Address:

Address:

How will your support network notify you of an approaching disaster?
How will you notify your support network?

Describe support network notification process here:

Evacuation plan: How would you leave town? Does your support network know your plans? Consider at least two routes out whenever possible.

Route 1

Public transportation may be interrupted or unavailable depending on the disaster. Will your support network help?

List alternate transportation plan from your support network here:

Medical Concerns

List any tests or treatments you take on a regular basis that will need to continue even in an emergency

Tests/ treatments	How often	How long can I go without	Comments
Ex. Blood test	1 time a week	? days	Coagulation therapy

Current Medications

Include names and doses of all medications including over the counter products. Please use additional paper if necessary.



Meds	Dose	Route (by mouth, injection , etc.)	How often you take	Prescription = (P) Over the Counter =(O)	Renewal date

List any ALLERGIES you may have to medications, food, or other allergens (ex., latex gloves or products)

Allergy: Do not give this medication!	Type of reaction

Make copies of prescriptions for your Go-Bag.



Equipment

List model numbers, vendor contact information and any other information needed to secure any equipment or assistive devices you will need whether at home or in a shelter.

Equipment/ supplies	Model number	Vendor	Vendor Contact #	Comments

Health Care Providers

In an emergency your support network or emergency personnel need to know who your health care providers are.

Health Care Provider Name	Specialty	Phone Number	Fax Number	Comments

Ask your doctor or health care provider about...

Medication

- What are substitutes for my medication?
- A list of most important medications or equipment that needs to be replaced immediately
- How much of my medications shall I keep for an emergency?
- How do I reach my doctor in an emergency when the telephone may be out?
- Who is my doctor's backup?
- What else do I need to think about?

Ask your equipment vendor...

If you use life-supporting technology or equipment:

- Do you know how to replace equipment fast?
- What do you need to do if the electricity fails?

Possible options might include the following:

- Substitutions for treatment or equipment
- Purchasing portable battery operated equipment
- Buying a DC inverter (Before buying, check with your medical equipment vendor to assure compatibility)

Contact your vendor now to ask about service during power outages.
Ask your medical supply vendor:

Will my backup supply last at least 48 hours? If not, find out what to do to get at least 48 hours of back up

Will you deliver additional equipment or supplies in threatening weather or other emergency?

How should I store equipment such as oxygen cylinders?

What supplies will I need for my cleaning equipment? Ask for a written procedure for cleaning the equipment

What is vendor's plan to replenish my equipment and supplies after the storm/disaster?

Important Documents

Make copies of important documents: (Check off list as you collect information.) Keep in a waterproof, portable container.

☐

Birth certificates

☐

Licenses

☐

Social security card

☐

Bank/credit cards

☐

Passports

☐

Insurance information (health, car, home, etc.)

☐

Wills/deeds

☐

Stocks/bonds

☐

Prescriptions

☐

Immunization information

☐

Proof of address

☐

Inventory of household valuable goods

☐

Other _____

Go-Bag

Collect a Go-Bag of critical supplies and personal items in case you have to leave immediately. Leave the Go-Bag close to the door/exit. Tell your support network where it is.

(Check off the list as you collect items for your “go bag.”)

☐

Documents collected from the previous list

☐

Include food for specific diets

☐

A manual can opener

☐

A flashlight and extra batteries

Information you or someone else might need about your disability or health condition

☐

Cash (as much as you can afford)

☐

Sanitation and hygiene items

☐

First aid kit

☐

Whistle



- ☐ Change of clothes (consider potential weather conditions--coat, boots, mittens, etc.)
- ☐ Small cooler with ice packs (kept in freezer until ready to go)
- ☐ Supplies for cleaning respiratory or other equipment (vinegar, water, liquid detergent, a dish pan and paper towels)
- ☐ Sunscreen
- ☐ Any other specific items you need (hearing aid batteries, ostomy supplies, extra inhaler, urinary bag and tubing, etc.)
- ☐ Food, vaccination information and veterinary contact for service animal

Service Animal Information:

Practice Your Plan

Practice your plan and make changes based on new information.

Locate the nearest accessible shelter. Contact the shelter manager whenever possible to discuss potential accommodation needs.

Discuss with your family and support network any other accommodations you need to plan for ahead of a disaster.

List plan modifications here after practicing your plan:

List additional considerations and accommodations here:

Registration with Emergency Services

Some communities have developed procedures for people with disabilities to register in order to let Emergency Management personnel know who you are and maybe what your needs are. This may be the E-911 registration, part of a city census, or a separate procedure. This information will be kept confidential and used only in case of emergency.

Please consider registering if you have the opportunity.

Final Thoughts

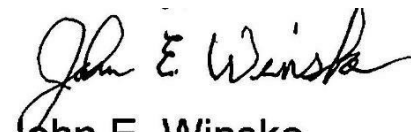
We, at the Disability Policy Consortium (DPC), hope you found this booklet helpful. When it comes to preparing for an emergency, we can never be too careful. While our local communities are required to serve all residents equally, we as responsible citizens must do our part. Having a completed personal emergency plan is a big step in being prepared. So congratulations!

If you liked this booklet, we hope you will consider joining the DPC. Our mission is to promote inclusion, independence and empowerment by guiding statewide development of policies to ensure that programs and services enable people with disabilities to participate in the political, economic and social mainstream of the Commonwealth of Massachusetts.

Since 1996, the DPC has ensured that people with disabilities have a seat at the table when laws are written and public policy changes are considered.

Our work fighting architectural, attitudinal and communication barriers has made Massachusetts a better place to live for the nearly one million citizens who are living with a disability.

Sincerely,

A handwritten signature in black ink that reads "John E. Winske". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

John E. Winske
Executive Director

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