Consumer-Employed Provider Program
Homecare Worker Guide Acknowledgment

By signing this document, I _____ am confirming the following:

- I received a copy of the Homecare Worker Guide.
- I understand I am responsible to read the guide in its entirety.
- I will ask the local APD/AAA office for help understanding the information if I have questions.
- I understand I cannot be or act as a consumer-employer's authorized representative if I am that consumer-employer's homecare worker.
- I understand I am a mandatory reporter 24 hours per day, seven days per week and must report abuse or suspected abuse of an elder, child or resident of any age in a nursing facility.
- I understand I am required to report abuse or suspected abuse during working hours involving an individual who receives services through a community mental health or community developmental disabilities program.
- I understand I must comply with investigations conducted by Adult Protective Services.
- I understand committing fraud will result in the termination of my provider enrollment and number and is punishable by law. I understand the following:
  - I cannot bill for any hours I did not work.
  - I cannot bill for tasks I did not do or that are not listed on the task list.
  - I cannot participate in any scheme to exaggerate or fabricate the consumer-employer's needs or the type of help I provide to the consumer-employer.
  - I cannot bill for hours when the consumer-employer is not eligible to bill for services. Examples of non-billable times include, but are not limited to, hospitalization; residing in another service setting; incarceration; or being out of town or the state or country when I have not gone with the consumer-employer to provide care.
  - I cannot bill for hours when I was out of town, the state or the country or otherwise unavailable to provide services on the task list to the consumer-employer.
  - I cannot bill for travel time unless I was traveling directly between consumer-employers in the same day and I was not conducting personal business or business for other consumer-employers.

Oregon Department of Human Services

OREGON Home Care COMMISSION

  - I cannot subcontract work and still bill for hours another person worked in my place.
  - I cannot cover for another homecare worker and allow that worker to bill for the hours I worked.
  - I cannot claim service-related mileage I did not drive in my vehicle.
- I understand I will report any suspected fraud, including fraud perpetrated by my consumer-employer, to the local APD/AAA office or to the ODHS Fraud Hotline.
- I understand I am required to keep all information involving my consumer-employer confidential and can only share information with the consumer-employer's case manager or the community health registered nurse working with my consumer-employer.

Signature of homecare worker _____ Date _____

FOR OFFICE USE ONLY	
☐ Signed form meets alternate method of orientation	Provider number
☐ Form signed in addition to in-class orientation	_____
☐ Date signed form received by local office: _____	☐ Career HCW
☐ Local office staff initials: _____	☐ Restricted HCW
☐ HCC staff initials, if verified by HCC: _____	