

Participant Direction Option (PDO) Representative Agreement Registration Form

I, _____, agree to serve as the representative for _____, who is participating in the Participant Direction Option (PDO). I know that I will be responsible for the following:

Please initial each line below to show that you have read and understand each item.

_____ 1. I have received a copy of the PDO Guidelines. I will read the guidelines; it tells me how the PDO works and explains my responsibilities.

_____ 2. I will reach out to the participant's Care Coach if I need help or have questions.

_____ 3. I will involve the participant as much as they wish to be involved with any PDO decisions made.

_____ 4. I agree that I am responsible for interviewing, hiring, training, and supervising the participant's direct service worker(s).

_____ 5. I agree that I will hire a qualified direct service worker(s). The qualifications for direct service workers are in the PDO Guidelines. I should hire a direct service worker(s) who is trained in universal precautions, HIPAA privacy standards, CPR and First Aid when possible.

_____ 6. I will create a list of job duties and a work schedule for the participant's direct service worker(s). The list of job duties and work schedule must be written on the Participant/Direct Service Worker Agreement.

_____ 7. I will make sure that the participant's direct service worker(s) does not work more hours than approved on the Participant/Direct Service Worker Agreement. I will also make sure that if more than 40 hours per week of a service are authorized, that there are more than one direct service worker for the participant. I also agree to only request services that are specified in the Participant/Direct Service Worker Agreement.

_____ 8. I know that I can get more training if I need it. I will contact the participant's Care Coach if I want more training on the PDO.

_____ 9. I know that the direct service worker's EVV time entries must be correct and electronically acknowledged by me.

_____ 10. I will submit the direct service worker's timesheets to the participant's Plan. The timesheets must be sent in by the date on the payroll schedule.

_____ 11. I will tell the participant's Care Coach if I think termination is necessary for a direct service worker. I will not terminate a worker without talking to the Care Coach.

_____ 12. I know that I will not be paid to be the representative for the participant. This is a voluntary position.

_____ 13. I know that I cannot be a direct service worker for the participant.

_____ 14. I will create an Emergency Back-up Plan so I will know what to do if the participant's direct service worker(s) is unable to report to work or provide direct services.

_____ 15. I know that I have the option to stop being the representative at any time. I will tell the participant and the participant's Care Coach if I wish to stop being the representative. The Care Coach will help the participant choose another representative.

_____ 16. I will follow the requirements on this Representative Agreement, the PDO Consent Form, the Participant/Direct Service Worker Agreement, the Participant Agreement, and the PDO Guidelines. If I do not follow the requirements, the participant's Plan may not allow me to continue to be the representative. If the Plan does not allow me to be the representative, the participant's Care Coach will help the participant choose another representative.

Please sign on the line below to show that you have read and understand each item in this agreement. If you have questions, please ask the participant's Care Coach to help you.

Representative's Printed Name	Signature	Date
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Participant's Printed Name	Signature	Date
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Care Coach's Printed Name	Signature	Date
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ENGLISH: This information is available for free in other languages and formats. Please contact our Customer Service number at **800-477-6931**. If you use **TTY**, call **711**, Monday – Friday, 8 a.m. to 8 p.m.

SPANISH: Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Cliente llamando al **800-477-6931**. Si usa un **TTY**, marque **711**. El horario de atención es de lunes a viernes de 8 a.m. a 8 p.m.

CREOLE: Enfòmasyon sa a disponib gratis nan lòt lang ak fòma. Tanpri kontakte nimewo Sèvis Kliyan nou an nan **800-477-6931**. Si ou itilize **TTY**, rele **711**, Lendi - Vandredi, 8 a.m. a 8 p.m.

FRENCH: Ces informations sont disponibles gratuitement dans d'autres langues et formats. N'hésitez pas à contacter notre service client au **800-477-6931**. Si vous utilisez un appareil de télétype (**TTY**), appelez le **711** du lundi au vendredi, de 8h00 à 20h00.

ITALIAN: Queste informazioni sono disponibili gratuitamente in altre lingue e formati. La preghiamo di contattare il servizio clienti al numero **800-477-6931**. Se utilizza una telescrivente (**TTY**), chiami il numero **711** dal lunedì al venerdì tra le 8 e le 20:00.

RUSSIAN: Данную информацию можно получить бесплатно на других языках и в форматах. Для этого обратитесь в отдел обслуживания клиентов по номеру **800-477-6931**. Если Вы пользователь **TTY**, звоните по номеру **711** с понедельника по пятницу, с 8.00 до 20.00.

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **800-477-6931 (TTY: 711)**. We are available Monday through Friday, from 8 a.m. to 8 p.m. Eastern time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
If you need help filing a grievance, call **800-477-6931** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the
U.S. Department of Health and Human Services, Office for Civil Rights
electronically through their Complaint Portal, available at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Auxiliary aids and services, free of charge, are available to you. **800-477-6931 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **800-477-6931 (TTY: 711)**.

Español: (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **800-477-6931 (TTY: 711)**.

Kreyòl Ayisyen: (French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **800-477-6931 (TTY: 711)**.

Tiếng Việt: (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **800-477-6931 (TTY: 711)**.