PERSONAL CARE
Employment Status Agreement

(Agreement to be completed after member becomes employed.)

Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ Date: _____

_____ _____
Provider Number Name/Title of Person Monitoring

Plan Dates: From: _____To: _____

(Check all applicable categories)

_____I have obtained full employment.
I am working at least forty (40) hours per month at or above minimum wage. I agree to provide this agency documentation of my employment on a Member Wage and Hour Report Form every three months.

_____I have obtained partial employment. My employer has indicated he/she will be able to offer full employment at a later date.
I am working less than forty (40) hours per month due to: _____

I expect to be working at least forty (40) hours per month on or about _____. I agree to provide this agency documentation on my employment on a Member Wage and Hour Report Form every three (3) months.

_____I have obtained partial employment. However, my employer has indicated that he/she will <u>not</u> be able to offer full employment.
I am working less than forty (40) hours per month due to:
_____.

I agree to continue Job Seeking and have entered into a Job Seeking Agreement. I agree to provide this agency documentation of my employment on a Member Wage and Hour Report Form every three (3) months.

I understand that personal care services will be provided outside the home when I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am partially employed, working less than forty (40) hours per month. I agree to notify my provider agency immediately of any change in my enrollment status. My provider agency will monitor the Employment Status Agreement and maintain records of the agreement in my Medicaid file for review by the Bureau of Medical Services.

Member's Signature Print Name

Agency Signature Date