

CEREBRAL PALSY OF MASSACHUSETTS, INC.
MassHealth PCA Program
PCA Signature Form

All PCAs hired by the PCA Consumer must complete and sign this page and give to their employer (the PCA Consumer) to submit to the fiscal intermediary (FI), along with other paperwork required by the FI. The FI cannot pay the PCA until all required paperwork is received and complete.

I agree to accept the position of Personal Care Attendant (PCA) for _____.
(Print Employer (Consumer's) name)

I have read or had explained to me the duties and responsibilities of a Personal Care Attendant and agree to perform those duties and responsibilities during the hours designated by the PCA Consumer. **I understand that my employer is the PCA Consumer**, who may be required to appoint a surrogate to assist my employer in managing the PCA program. I understand that I must notify my employer and my employer's surrogate, if any, of any changes in my circumstances that would affect my ability to perform my duties as a PCA.

I understand that I must complete and provide accurate Activity Forms (timesheets) in a timely fashion, and that the FI will issue a check to my employer (the PCA Consumer), who is responsible for paying me (unless I have requested my check be directly deposited into my bank account). I agree to provide proof of my identity to my employer to complete the *Employment Eligibility Verification* (form I-9) that the Department of Homeland Security requires all employees to complete (the FI will give my employer this form).

I understand that providing false or misleading information to my employer (the PCA Consumer), my employer's surrogate, the Fiscal Intermediary, the Personal Care Management agency, or MassHealth may be considered fraud and may result in a referral to the Office of the State Auditor's Bureau of Investigations or to the Office of the Attorney General.

I understand that I cannot be paid as a PCA if I am my employer's (the PCA Consumer) spouse, minor child, parent (if the PCA Consumer is a minor child), surrogate, foster parent, or legally responsible relative.

The following represents my relationship to my employer (the Consumer): **PLEASE CHECK ONE:**

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

I hereby state that I understand my duties, rights and responsibilities as a Personal Care Attendant and that all the information I have provided to my employer (the PCA Consumer) and to the Fiscal Intermediary is true and accurate to the best of my knowledge.

Print PCA Name: _____

PCA Signature: _____

Date: _____

Employer (Consumer) or legal guardian signature: _____

Consumer Number: _____

Date: _____