ABI/MFP Waiver Self-Direction:

Direct Care Worker Overtime Request Form

This form is to be used by MassAbility waiver case managers and DDS service coordinators with waiver participants who need their direct care workers (DCWs) to work over 50 but not more than 66 hours per week. Complete this form with your waiver participants and submit it to your supervisor for approval.

Overtime is calculated in total. This means that a DCW working for more than one waiver participant must consider all of the hours they work for other waiver participants. This will help them determine if their waiver participant needs to ask for an authorization for the DCW to work overtime. If the DCW also works as a PCA, those PCA hours must also be considered.

GENERAL INFORMATION

Case Manager/Service Coordinator Information

Agency (MassAbility or DDS)	
Requesting MassAbility case manager or DDS service coordinator (first and last name)	
Phone	Email

Waiver Participant Information

Waiver participant name		Date of birth
MassHealth ID	Waiver (MFP-CL, ABI-N, MFP-RS, or ABI-RH)	
Waiver participant phone and email		
Waiver participant address		
Surrogate name (if applicable)		
Surrogate phone and email (if applicable)		

Direct Care Worker (DCW) Information

DCW name	DCW unique identifier number
DCW address	
DCW phone and email	
Waiver service(s) being provided by DC	

Request Authorization Type

Please select the type of overtime authorization you're requesting. An individual DCW is limited to working no more than 66 hours per week under any circumstances.

☐ Temporary authorization (go to **Section A**) *This may be requested for up to 12 weeks.* ____ *Check here if this request is needed to accommodate a DCW/PCA whose hours working for other employers results in more than 50 hours in total.* ____ *Check here if this request is needed to accommodate a DCW/PCA whose hours working for this employer results in more than 50 hours in total.*	☐ Continuity-of-care authorization (go to **Section B**) *This may be requested for up to one year (or up to the time of the next review of the Plan of Care).* ____ *Check here if this request is needed to accommodate a DCW/PCA whose hours working for other employers results in more than 50 hours in total.* ____ *Check here if this request is needed to accommodate a DCW/PCA whose hours working for this employer results in more than 50 hours in total.*

Waiver Participant Name: _____

SECTION A: TEMPORARY AUTHORIZATION

Please specify the length of the overtime authorization you're requesting and the waiver service being provided by the DCW. This may be requested for up to 12 weeks.

Please specify the length of the overtime authorization you are requesting.

Dates from _____ to _____

Waiver service(s) being provided by this DCW _____

Temporary authorization requests will be approved when one or more of the following circumstances are present.

☐ I need more time to hire additional DCWs. *(Please check one)*

- ☐ I placed multiple ads/used multiple resources for seeking DCWs, but received no responses for DCWs who could appropriately fulfill my needs.
- ☐ I interviewed multiple DCWs, but no DCW would accept the position.
- ☐ The DCW I hired didn't remain in my employment because the DCW couldn't attain the basic knowledge to carry out the DCW-assigned tasks safely.
- ☐ The DCW left employment suddenly.

☐ I'll be traveling within the U.S. territories, and it's not possible to bring more than one DCW.

☐ My informal supports are unavailable, or less available, to help me. *(Please explain in space provided.)*

_____

_____

_____

☐ One or more of my DCWs needs to take a short-term leave for one of the following reasons. *(Please check one.)*

- ☐ In school, or temporarily unavailable due to school
- ☐ Medical or family leave
- ☐ Maternity/paternity leave
- ☐ Sick leave
- ☐ DCW going on vacation

☐ I am receiving hospice care.

☐ I have a temporary need to schedule an individual DCW to work over 50 but not more than 66 hours per week. Temporary medical needs include post-acute hospitalization or post-skilled nursing facility. *(Please describe the circumstances.)*

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_____

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_____

Waiver Participant Name: _____

SECTION B: CONTINUITY-OF CARE-AUTHORIZATION

Please specify the length of the overtime authorization you're requesting and the waiver service being provided by the DCW. This may be requested for up to one year (or up to the time of the next review of the Plan of Care).

Dates from _____ to _____

Waiver service(s) being provided by this DCW _____

Continuity-of-care authorization requests will be approved when one or more of the following circumstances are present.

☐ I need more time to hire additional DCWs. *(Please check one)*

- ☐ I placed multiple ads/used multiple resources for seeking DCWs, but received no responses for DCWs who could appropriately fulfill my needs.
- ☐ I interviewed multiple DCWs, but no DCW would accept the position.
- ☐ The DCW I hired didn't remain in my employment because the DCW couldn't attain the basic knowledge to carry out the DCW-assigned tasks safely.
- ☐ The DCW left employment suddenly.

☐ I have an ongoing medical need that requires intensive care. I need to schedule my DCW to work additional hours, and I've made a documented effort to try to hire an additional DCW. *(Please explain in space provided.)*

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☐ I am receiving hospice care.

Waiver Participant Name: _____

ATTESTATION (ORIGINAL SIGNATURES REQUIRED)

WAIVER PARTICIPANT/SURROGATE

I certify that I have reviewed and confirm that the information contained in this document is true and accurate. I understand that falsification, omission, or concealment of any material fact contained in this document may result in the determination that I require a surrogate to manage my DCW 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 in this document. This documentation will be kept by my case manager or service coordinator in my record. 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 630.000 and 130 CMR 450.204 and 450.205.

Waiver participant | Date

Surrogate signature (if applicable) | Date

DIRECT CARE WORKER

I certify that I have reviewed and confirm that the information contained in this document 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 in this document. This documentation will be kept by the case manager or service coordinator in the waiver participant's record. 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 630.000 and 130 CMR 450.204 and 450.205.

DCW signature | Date

CASE MANAGER / SERVICE COORDINATOR ONLY

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

Case manager/service coordinator name

Case manager/service coordinator signature | Date

Print Clear

Waiver Participant Name: _____

INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THE OVERTIME REQUEST FORM

INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THIS FORM

You, the waiver participant 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 case manager or service coordinator. Submit this form and required documentation to your case manager or service coordinator.

WAIVER PARTICIPANT INFORMATION

Include your name, address, phone number, email address, MassHealth ID number, and date of birth. If you have a surrogate, include your surrogate's name and phone number.

DIRECT CARE WORKER INFORMATION

Provide your DCW's name, address, phone number, email address, and unique identifier number, located on your DCW's activity sheet. If you don't know your DCW's unique identifier number, contact your fiscal intermediary.

REQUEST OVERTIME TYPE

Indicate which request type you're seeking. If you're approved to schedule a DCW to work more than 10 hours of overtime (i.e., over 50 hours) per week, the number of approved hours won't exceed the amount of your total approved hours.

DCWs are limited to working no more than 66 hours per week across waiver participants.

SECTION A: TEMPORARY AUTHORIZATION

You must obtain a temporary authorization for your DCW to work more than 10 hours of overtime (i.e., over 50 hours) per week to avoid a disruption in care while you look to hire additional DCWs, if applicable.

SECTION B: CONTINUITY-OF-CARE AUTHORIZATION

Continuity-of-care authorization requests will be approved when one or more of the listed circumstances are present.

ATTESTATION

GENERAL SIGNATURE REQUIREMENTS

The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature. Please see the following for specific requirements.

WAIVER PARTICIPANT/SURROGATE

You and your surrogate, if any, must sign and date the form and certify that all information on the form is true, accurate, and complete. Electronic signatures are acceptable.

DIRECT CARE WORKER

Your DCW must sign and date the form and certify that all information in the form is true, accurate, and complete. Electronic signatures are acceptable.

CASE MANAGER/SERVICE COORDINATOR

The case manager or service coordinator must fill in their name; sign and date the form; and certify that the information is true, accurate, and complete to the best of their knowledge. Electronic signatures are acceptable.

ALL DOCUMENTS MUST BE KEPT IN THE WAIVER PARTICIPANT'S RECORD.