Appendix H |

IFDS Representative Agreement

Member name: _____

Member's LRP(s) (if applicable): _____

Member record number: _____ Representative type: ☐ Voluntary ☐ Mandatory

IFDS Option: ☐ Employer of Record ☐ Agency with Choice

Employer of Record/Managing Employer: _____

Prospective Representative: _____

I, as proposed Representative for the above-named Employer of Record/Managing Employer,

- Have been advised of the requirements of the NC Innovations Individual and Family Directed Services (IFDS) Option identified above.
- Have attended the initial orientation training for the IFDS Option identified above.
- Have attended the self-direction training for the IFDS Option identified above and had the opportunity to have my questions concerning the training and employer functions for which I may be responsible answered.
- Have received a self-direction training completion certificate issued by the Community Navigator agency of the member's choice.
- Have read and understand the Vaya Health IFDS Employer Handbook.
- Have read "Attachment H: Individual and Family Directed Services" of the NC Medicaid Clinical Coverage Policy 8-P: NC Innovations.
- Understand that I may, with the Employer of Record's/Managing Employer's consent, use periodic or monthly Community Navigator Services to receive on-going training and consultation in the implementation of the IFDS Option.
- Understand that I cannot be paid for being the Representative.
- Have honestly and openly shared my capabilities and limitations with the care manager when completing the IFDS Assessment.
- Understand that Vaya Health must approve me as the Representative.
- Understand that I must comply with Vaya Health, state, and federal requirements for Employer of Record/Managing Employer duties for which I may be responsible.
- Understand that if I do not follow these requirements that Vaya Health may remove me as the Representative for this Employer of Record/Managing Employer.
- Understand that the Employer of Record/Managing Employer may elect to remove me as the Representative at any time.

I agree to serve as the Representative for the above-named Employer of Record/Managing Employer and understand my responsibilities and duties under the Individual and Family Directed Services Option of the NC Innovations Waiver. I have read and signed an IFDS Agreement that specifies the duties that the Employer has requested that I perform and agree to abide by terms of this Agreement. I understand that my appointment as Representative is subject to approval by Vaya Health.

Representative signature _____ Date signed _____

I hereby ☐ approve / ☐ disapprove of the above-referenced person to serve as the Representative for the above-named Employer of Record/Managing Employer:

Care manager signature _____ Date signed _____