Vendor Fiscal/Employer Agent (VF/EA)
Financial Management Services (FMS)

DIRECT CARE WORKER (DCW) QUALIFICATION FORM

1. Person Being Qualified: ☐DCW ☐Back-up DCW

2. DCW or Back-up DCW Information and Attestation:

Name: (Print/type) _____

Address: _____
(Number) (Street) (Unit/Apt)

_____
(City) (State) (Zip Code)

Home Phone Number: ____/____/_____ Cell Phone Number: ____/____/_____

E-mail Address: _____

Date Common Law Employer Qualified Worker/Staff: _____

By signing this form, I, _____, do verify, that:
(Print Name of Direct Care Worker)

I have read and/or have had the Participant Service Plan read to me, and I understand the requirements.

I attest that I shall report a change in my qualification status (listed below) to my Common Law Employer within 5 business days of the change occurring.

DCW Signature: _____

DCW Social Security Number: _____

Date Signed by DCW: _____

3. Type of Qualification:

☐ Initial Qualification ☐ Re-verification of qualification as required by the approved Waiver
Calendar year: _____

☐ Change in Qualification Status:

☐ Adding Service(s): (Print/type service name) _____

☐ Deleting Service(s): (Print/type service name) _____

OLTL services are: Personal Assistance Services (PAS), Participant-Directed Community Supports, and Respite.

Please verify the following qualifications for the person that provides the participant-directed services by **initialing all** mandatory qualification requirements in Section 1 and **initialing only those** qualification requirements that apply in Section 2.

Qualification Validation (Initial All)	**Section 1. Mandatory Qualification Requirements**
	At least 18 years of age
	Possess a valid Social Security Number
	Possess basic math, reading and writing skills
	Demonstrates the capability to perform health maintenance activities specified in the participant's service plan OR Completion of pre-training or in-service training necessary to carry out the participant's service plan
	Agrees to carry out the service responsibilities outlined in the participant's service plan
	Criminal History Background Check (When the Applicant is and has been a Pennsylvania resident for at least 2 years immediately preceding the date of application
Qualification Validated - If Applicable (Initial)	**Section 2. Qualification Requirements - If Applicable**
	Federal Bureau of Investigation (FBI) Clearance (When the Applicant is not and, for two years immediately preceding the date of application, has not been a resident of Pennsylvania
	Child abuse clearance per Child Protective Services Law (CPSL) in accordance with 23 Pa. C.S. Chapter 63 (When the Participant receiving services is under 18 years of age or there is a child under age 18 residing in the home of the individual receiving services)
	Valid driver's license (If transportation is provided as part of the service)
	Automobile insurance for all automobiles used as part of the service (If transportation is provided as part of the service)
	Current state motor vehicle registration (If transportation is provided as part of the service)

4. VF/EA FMS Participant Information:

Name of Participant: (Print/type) _____

Name of Common Law Employer: (Print/type) _____

Common Law Employer's Address: _____
(Number) (Street) (Unit/Apt)

_____
(City) (State) (Zip code)

Common Law Employer's Home Phone Number: _____/_____/_____

Common Law Employer's Cell Number: _____/_____/_____

Common Law Employer's E-mail Address: _____

5. Common Law Employer Attestation:

By signing this form, I, _____, do verify, that:
(Print Name of Common Law Employer)

I have read and/or have had read to me the requirements of being the Common Law Employer in the applicable waiver, and I understand these requirements.

I verify that I will submit all required DCW qualification documentation to the VF/EA.

I also verify that I am in compliance with the waiver requirements. I attest that I shall report a change in my DCW's qualification status, by submitting a new *Direct Care Worker (DCW) Qualification* to the VF/EA FMS organization within 5 business days of being notified of the change.

Signature of Common Law Employer: _____

Social Security Number Common Law Employer: _____

Date form completed by Common Law Employer: _____

_____

For VF/EA FMS Use

6. Receipt of verification by VF/EA FMS:

Signature of VF/EA FMS Representative: _____

Date form Received by VF/EA FMS: _____

MAIL FORM TO:
Current Vendor