**Employment Agreement**

This agreement is made on **[Insert date]** between **[Insert name of individual directly employing the worker]** (“employer”) and [Insert name of employee] (“employee”) to describe the supports that the employee will provide to the employer and the terms and conditions of employment

**Article I - EMPLOYEE RESPONSIBILITIES**

I, **[Insert name of employee]** (employee) am aware and agree that my employment is conditioned on my employer’s use of self-directed services administered by the CMHSP. If my employer stops using self-directed services, my employment may end. I agree to the following terms of employment:

1. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.
2. I agree to assist my employer to maintain the documentation and records required by my employer or the CMHSP. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay. All records I may have or assist to maintain are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports, when necessary, as required or requested by my employer.
3. [**Optional Provision:** I shall immediately notify **(insert the name and contact information of the contact individual chosen by the employer** (for example, it may be an ally) if my employer experiences a medical emergency or illness. I will also notify **(insert name of contact individual)** before taking my employer to the physician, except in case of an emergency.]
4. I agree to abide by all of my employer’s rules (described below) regarding my employment duties to the employer and I acknowledge receipt of the following rules and regulations
	1. Attachment A (Job Description) to this Agreement, which outlines the supports that I will provide to my employer.
	2. **[Employer should insert rules he or she may have (such as rules regarding phone usage or smoking in his or her home)].**
	3. **[Insert reporting and documentation requirements for verifying hours worked].**
5. I understand that this is an employment at will relationship, which can be terminated by me or by my employer at any time. However, my employer cannot terminate my employment based on my race, religion, sex, disability, or other protected status under federal or Michigan law. In addition, I agree to give **[insert number of days]** days written notice to my employer if I terminate my employment.
6. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the CMHSP, which authorizes the supports I provide, or the financial management service, which is the financial administrator of funds used to pay me.
7. I agree to assist my employer in filing Recipient Right complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I observe. I understand that I may be requested to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights.
8. I agree to not to sue the financial management service for its role as the financial administrator of my employer’s individual budget and the CMHSP for its role in administering self-directed services.
9. I agree to execute a Medicaid Provider Agreement with the CMHSP and acknowledge that this agreement does not alter the fact that the CMHSP is only the administrator of the funds used through self-direction, and that my employer is **[insert name of employer].** I understand that my employment is contingent on completing this agreement.

**Article II EMPLOYER RESPONSIBILITIES**

I, **[insert name of Employer]** (“Employer”) agree to the following:

1. I will provide my financial management service with the necessary documentation to assure timely compensation of my employee.
2. I will maintain all required documentation and provide to the CMHSP when requested.
3. I will compensate my employee in the following manner: $ **[Insert hours wage]** an hour. **[Insert specific information about any benefits the employee shall receive and describe benefits that will be excluded.]** Payroll will be handled by my financial management service **[Insert name of financial management service],** which will withhold all necessary tax, unemployment, and other withholdings from the employee’s paychecks.
4. I will assure my employee receives required training initially and ongoing.
5. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports.
6. I will assure that my employee executes a Medicaid Provider Agreement with the CMHSP.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Signature** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian/legal representative (if applicable)** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Signature** Date