

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING

CAREGIVER SUPPORT PROGRAM

Conditions of Participation
Certificate of Accountability

I, _____, Primary Caregiver, for _____, Care Receiver, certify that all information that I have provided during assessment and throughout my enrollment in the Caregiver Support Program is true and accurate to the best of my knowledge. I agree to comply with all program requirements. I understand that this document will serve as an agreement between myself and the Area Agency on Aging (AAA) and may be used as a basis for the recovery of reimbursements if I am determined to be in violation of this agreement.

My signature indicates that I understand, and am in agreement with, the following terms and conditions of the Caregiver Support Program:

- I have assumed the primary responsibility for the provision of care needed to maintain the physical and/or mental health of this Care Receiver and am actively involved with all aspects of the Care Receiver's care on a regular, but not necessarily daily, basis.
- I understand that I may not receive reimbursement for personally providing caregiving services to my Care Receiver.
- I certify that I have **never**:
 - been convicted of a crime relating to abuse, neglect, exploitation or abandonment
 - been found civilly liable for abuse, neglect, exploitation or abandonment
 - been notified that I am an alleged perpetrator in a substantiated report of need for protective services under The Older Adults Protective Services Act, The Adult Protective Services Act or The Child Protective Services Act.
- I understand that this is not an entitlement program. Reimbursement is based on my needs in support of my Care Receiver, income eligibility and availability of funds.
- I understand that I have the right to appeal decisions made by the AAA regarding program eligibility or the denial, termination or reduction of services.
- I agree to annually provide verification of the Care Receiver's household income. I agree to provide additional income documentation, if requested.
- I understand that if I hire or devise any form of agreement or arrangement for an individual(s), party or entity to assist in the provision of care or respite to my Care Receiver, I assume all risks associated with said care arrangement and hold harmless the AAA from any and all claims, liabilities and costs related to the hiring, agreement or arrangement with the individual(s), party or entity to provide care to the Care Receiver.
- I understand that all purchases must be approved in advance by my Care Manager and must be directly related to the specific needs of my Care Receiver. I will provide documentation for all expenses for which reimbursement is being requested.

- Attach to SAMS record
- Copy to the Caregiver

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- I understand that I cannot be reimbursed for general supplies that may be used by others within the household (i.e., toilet paper, shampoo, soap, etc.).
- I understand that my calculated reimbursement percentage will be applied to the receipts submitted to determine the amount that I will be reimbursed.
- I understand that I have the ability to accumulate reimbursement benefits for use at a later date and that, prior to use of these benefits, a plan approved by my Care Manager must be in place. Accumulated benefits (used for planned absences, such as an extended respite) can only be accumulated for a six month period and cannot be carried past June 30th of each calendar year.
- I understand that reimbursement for pre-approved home modifications and assistive devices (up to a lifetime maximum of \$2000) will be subject to my calculated reimbursement percentage and will depend upon the availability of funds.
- I understand that the deadline for submission of monthly receipts is by the ____ of the month following the month in which the purchase was made. I agree to abide by such deadlines and submit receipts accordingly. I understand that failure to submit receipts by the deadline will result in denial of reimbursement and continuous failure to submit receipts by the deadline may result in disenrollment of the program.
- It is my responsibility to report to my Care Manager any changes in the status of my caregiving situation. Reportable changes include, but are not limited to, significant changes in the health status of my Care Receiver, living arrangements, household income, my ability to provide necessary care, and the availability of informal supports.
- By receiving services under the program, I am subject to administrative actions and penalties if I perform one or more of the following acts:
 - Making a false statement or causing a misrepresentation of a material fact regarding information affecting eligibility for benefits.
 - Submitting false or fraudulent documentation of caregiving expenses, for which reimbursement is sought or received.
 - Refusal to provide requested documentation for eligibility.

If I violate this agreement, the Area Agency on Aging has the authority to suspend or terminate services. If I receive reimbursement for which I am ineligible, the Agency may recover twice the amount of reimbursement determined to be appropriate, plus interest. The Agency also has the ability to initiate legal proceedings.

Primary Caregiver Signature

Date

Care Manager Signature

Date

- Attach to SAMS record
- Copy to the Caregiver