APPENDIX A.

PERSONAL PREFERENCE MATERIALS

RIGHTS AND RESPONSIBILITIES OF CONSUMER

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
State Office on Disability Services
Personal Preference Program

PARTICIPANT STATEMENT OF RIGHTS AND RESPONSIBILITIES

RIGHTS

I have the right to create a Cash Management Plan to meet my needs within the Personal Preference Program guidelines for use of the cash grant.

I have the right to change my Cash Management Plan to meet my needs within the program guidelines for use of the cash grant.

I have the right to be treated with dignity and respect.

I have the right to privacy and confidentiality.

I have the right to live as I choose, in my own home, free from judgment or interference.

I have the right to decide about how to spend my cash grant or to have someone I choose help me with decisions about the Personal Preference Program.

I have the right to bring whomever I wish to all meetings pertaining to the Personal Preference Program.

I have the right to file a complaint with the Personal Preference Program State staff at 1-888-286-3035 (**Toll Free**) for any reason, including being advised to disenroll.

RESPONSIBILITIES

I must notify my consultant within five days of admission to a hospital, nursing facility, rehabilitation facility, or any other institution. I understand that I am not entitled to my cash grant during the time I spend in a facility.

I must keep scheduled appointments.

I am responsible for hiring, supervising and firing my employees and all the responsibilities that go with hiring employees.

I must treat my employees, the consultant, and others who work with the Personal Preference Program the same way I expect to be treated.

I am responsible for what is included in my Cash Management Plan and for managing my cash grant accordingly.

I am responsible for all required paperwork and adhering to all tax and labor laws.

I am responsible for answering interview questions from Mathematica Policy Research.

I have read and /or understand these rights and responsibilities.

_____ _____
Participant/Representative signature Date

_____ _____
Consultant signature Date

PPR&R(12/98:6/99:7/99)

RESPONSIBILITIES OF REPRESENTATIVE

New Jersey Department of Human Services
Division of Disability Services
Personal Preference Program
(New Jersey Cash & Counseling Demonstration)

Representative Description

A representative may be a participant's legal guardian, a family member, or any other individual identified who willingly accepts responsibility for performing cash management tasks that the participant is unable to perform. A representative must evidence a personal commitment to the participant and must be willing to follow their wishes and respect their preferences while using sound judgment to act on their behalf. Representatives receive no monetary compensation for this service, and may not serve as an employee of the participant.

Specifically, the representative must be willing to:

- Work with the Cash & Counseling consultant to provide information to develop the cash management plan on the participant's behalf.

- Use the cash grant for the items outlined in the Cash Management Plan as the participant wishes.

- Maintain records, as required by the State, regarding expenditures and activity with the fiscal intermediary.

Representatives may be necessary for participants under certain conditions as defined below:

Voluntary Representative

The participant requests that a representative serve on their behalf, or a consultant recommends that the participant choose a representative and the participant agrees.

Predetermined Representative

The participant has a legal guardian or other court appointed representative in place at the time of enrollment and that individual will serve as the designated representative on the client's behalf.

Mandated Representative

The client is enrolled in Personal Preferences and has misspent funds from the cash allowance, or their functioning has deteriorated in such a way that they are no longer able to manage their cash benefit.

COLORED FLYER MAILED TO PCA RECIPIENTS

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
STATE OFFICE ON DISABILITY SERVICES
PO BOX 700
TRENTON NJ 08625-0700

CHRISTINE TODD WHITMAN
Governor

MICHELE K. GUHL
Commissioner
WILLIAM A. B. DITT
Executive Director
TEL (609) 292-7800

Do You Want Greater Independence, Personal Choice and Flexibility When Using Personal Care Services? Then Don't Miss This Exciting Opportunity!!!

September 2000

Dear Medicaid Personal Care Consumer:

New Jersey Medicaid is offering an exciting new program for people who need personal care assistance, called Personal Preference: New Jersey's Cash and Counseling Demonstration Program. This is a research program, Personal Preference will study people who buy their own personal care services and those who get services from an agency. One half of the people who agree to participate will receive a cash grant, while the other half will continue to get services the way they do now.

Personal Preference Allows You To Have More Control Over Your Care.

- You Make The Decisions!
- You Decide What Services You Want & Need!
- You Can Hire Anyone You Want; Relatives, Friends, Neighbors!
- You Can Purchase Equipment, Devices and Make Home Modifications!
- You Receive Money Every Month To Buy Your Own Personal Care Services!

IF YOU ARE INTERESTED, PLEASE CALL TODAY (TOLL FREE) 1-888-285-3036. THE CALL IS FREE, AND PERSONAL PREFERENCE STAFF WILL BE HAPPY TO SPEAK WITH YOU FURTHER.

Estado de New Jersey
DEPARTAMENTO DE SERVICIOS HUMANOS
OFICINA ESTATAL DE SERVICIOS A DISCAPACITADOS
P.O. Box 700
Trenton, NJ 08685-0700

CHRISTINE TODD WHITMAN
Gobernadora

MICHELE K. GUHL
Comisionada

WILLIAM A. B. DITTO
Director Ejecutivo
TEL. (609) 292-7800

¿Desea usted mayor independencia, selecciones personalizadas y flexibilidad al usar los servicios de cuidado personal? ¡Entonces no se pierda esta gran oportunidad!

Septiembre de 2000

Estimado cliente de servicios de cuidado personal de Medicaid:

Medicaid de New Jersey está ofreciendo un nuevo programa para personas que necesitan servicios de asistencia para el cuidado personal llamado Preferencia Personal: Programa de Demostración de Asesoría y dinero en efectivo de New Jersey. Éste es un programa de investigación que hará un estudio sobre personas que adquieren sus propios servicios de cuidado personal y aquéllos que los adquieren por medio de una agencia. Una mitad de las personas que acepte participar recibirá una subvención en efectivo, mientras que la otra mitad continuará obteniendo sus servicios de la misma manera en que lo hacen en la actualidad.

El programa Preferencia Personal le permite tener mayor control sobre su cuidado personal.

- ¡Usted toma las decisiones!
- ¡Usted decide cuáles son los servicios que necesita y desea!
- ¡Usted puede emplear a quien quiera: familiares, vecinos, amigos!
- ¡Usted puede adquirir equipo y dispositivos y hacerle modificaciones a su casa!
- ¡Usted recibe dinero cada mes para adquirir sus propios servicios de cuidado personal!

SI ESTÁ INTERESADO EN EL PROGRAMA, POR FAVOR LLAME HOY MISMO AL 1-888-285-3036. LA LLAMADA ES GRATUITA Y LOS REPRESENTANTES DE PREFERENCIA PERSONAL CON GUSTO HABLARÁN CON USTED.

NOTICE IN MULTIPLE LANGUAGES

State of New Jersey
Department of Human Services
State Office on Disability Services
Personal Preference Program

Important Notice

Please have this information translated immediately.

[Italian]	Importante! Fate tradurre quest'informazione immediatamente.
[Haitian Creole]	Trè enpòtan! Fè tradui sa a kounye an.
[French]	Important! Faites traduire cette information immédiatement.
[Portuguese]	Importante! Mande traduzir esta informação imediatamente.
[Polish]	Pilne! Proszę o niezwłoczne przetłumaczenie tej informacji.
[Chinese]	重要！請立刻將此信息翻譯成中文。
[Greek]	Προσοχή! Δώστε να σας μεταφράσουν αμέσως αυτές τις πληροφορίες.
[Vietnamese]	QUAN TRỌNG! CẦN DỊCH TIN TỨC NÀY NGAY.
[Cambodian]	ពត៌មានបន្ថែម! សូមបកប្រែនៅការប្រកាសនេះជាបន្ទាន់
[Laotian]	ຂໍ້ແຈ້ງຂ່າວ ! ຈົ່ງຮີບແປການປະກາດນີ້ໂດຍດ່ວນ
[Armenian]	*Կը խնդրուի այս տեղեկութիւնը անմիջապէս թարգմանել տալ:*
[Russian]	Внимание! Немедленно обеспечьте перевод настоящей информации!
[Spanish]	¡Importante! Por favor de traducir esta información inmediatamente.

CASH MANAGEMENT PLAN FORMS AND RELATED MATERIALS

STATE OFFICE ON DISABILITY SERVICES
PERSONAL PREFERENCE PROGRAM
Cash Management Plan

Consumer Name: _____ **Cash Grant Amount:** _____

Representative Name: _____ **Medicaid #:** _____

Type of Plan: (check one) Initial ☐ Revision ☐ Reassessment ☐ **Start Date:** _____

I. Direct Employment

Service Type/Description	Worker	Hourly Wage	Total Taxes Per Hour	Sum of Hourly Wages & Taxes	# of Hours Per Month	Total Monthly Cost
				Total Monthly Employment Costs		$

II. Purchase of Agency Services

Service Type/Description	Agency Name	Frequency	Unit Cost	Number of Units Per Month	Total Monthly Cost
				Total Monthly Agency Services Costs	$

III. Miscellaneous Expenses

Expense Type/Description	Provider Description	Frequency	Unit Cost	Total Monthly Cost
Cash				
Home / Workers Comp Insurance				
			Total Monthly Miscellaneous Costs	$

Consumer Name: _____ Medicaid #: _____

Representative Name: _____

IV. Special Purchases/Modifications

Description of Work/Purchase	Contractor/Provider Name	Proposed Purchase Date	Estimated Cost	Estimated # of Monthly Payments	Total Monthly Cost
				Total Monthly Special Purchase/Modification Costs	$

V. Fiscal Intermediary Services & Fees

Description of Services and Fees	# of Units	Unit Cost	Total Monthly Cost
Transaction Fees			
Criminal Background Investigation Fee			
Employee Health Insurance			
		Total Monthly Fiscal Intermediary Costs	$

Consumer Name: _____ **Medicaid #:** _____

Representative Name: _____

RECONCILIATION OF MONTHLY CASH BENEFIT

		Monthly Amount
A. Total Monthly Cash Benefit		$ -
B. LESS Cost of Direct Employment	(Section I)	$
C. LESS Cost of Agency Services	(Section II)	$
D. LESS Cost of Other Expenses	(Section III, IV)	$
E. LESS Cost of Fiscal Intermediary Services	(Section V)	$
(A minus the sum of B, C, D & E)	**MONTHLY BALANCE**	

Decision Tree Completed: Yes___ No___

CMP Designed By:

Consumer Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Consultant Review: _____ Date: _____

(Signature and Title)

Agency Name: _____ Phone# _____

State Program Office Approval: _____ Date: _____

PPPcmp 7/99:8/99 (Signature and Title)

STATE OFFICE ON DISABILITY SERVICES

Personal Preference Program

Instructions for Completing the Cash Management Plan

Please read through the directions carefully before entering information. If you have questions concerning the completion of the Plan please contact your Consultant. If your Consultant is not available, call the State Office On Disability Services at 1-888-285-3036 (toll free) for assistance.

Please complete the identifying information at the top of the first page of the Cash Management Plan as well as on pages two and three. Please check whether the plan is the Initial Plan, Revision, or was triggered by a Nursing Reassessment that resulted in a change.

SECTION I: DIRECT EMPLOYMENT

Service Type/Description: List all services you would like to receive through individual workers who will be directly hired and supervised by you, as the consumer.

Worker: List the name of the individual worker or workers you would like to employ to provide the services you need in this section. You should also list any worker that you would like to use as a back up so that they may be able to receive a pay check for future services provided. Indicate in this section whether the worker(s) listed will be a regular employee or a back up. *Please note*: the back-up worker wages and taxes are not to be counted in towards your total monthly costs.

Hourly Wage: List the hourly wage that you intend to pay each worker listed above.

Total Taxes Per Hour: Indicate the total hourly tax expense for each wage listed above. You may obtain this information from Community Access Unlimited (CAU), the Fiscal Intermediary by calling 1-877-354-9944.

Sum of Hourly Wages/Taxes: List the sum of the hourly wage and hourly tax expense for each worker listed.

Number of Hours Per Month: Multiply the number of hours per month you intend to hire each worker by 4.33.

Total Monthly Cost: Multiply the hourly wage and taxes by the number of hours per month to obtain the total cost per month for each worker you hire.

Total Monthly Employment Costs: Indicate the sum of the total cost per month for all workers hired.

SECTION II: PURCHASE OF AGENCY SERVICES

Service Type / Description: List all services you would like to receive through an agency. You should also indicate any agency that you would like to consider using as a back up. Please note: the back-up agency costs are not to be counted in towards your total monthly costs.

Agency Name: List the name of the agency you would like to use to provide the service listed.

Frequency: Indicate the frequency in which each service is purchased every month.

Unit Cost: List the unit cost you intend to pay for each service listed.

Number of Units Per Month: List the number of units of service per month you intend to purchase. For example, housekeeping service twice per month would be considered 2 units per month.

Total Monthly Cost: Multiply the number of units per month by the unit cost for each agency you plan to use.

Total Monthly Agency Services Costs: Indicate the sum of the total cost per month for all agencies listed, with the exception of backup agencies as previously stated.

SECTION III: MISCELLANEOUS EXPENSES

Expense Type / Description: List all other expenses you plan to have each month. Please note: you will need to include homeowner or renter's insurance or a rider to your insurance as regular expense to guarantee that your workers are covered for worker's compensation.

On the line that says "Cash" write the amount you will need in cash each month to buy things, such as supplies not covered under Medicaid or taxi fare.

Provider Description: Indicate the intended provider for each expense listed above. Describe any item or service you will purchase next to the cash line but under the provider description category.

Frequency: Indicate the frequency each expense item will occur every month.

Unit Cost: List the unit cost you intend to pay for each miscellaneous expense.

Total Monthly Cost: Indicate the total monthly cost for each individual expense.

Total Monthly Miscellaneous Costs: Indicate the sum of the total cost for all expenses listed above.

SECTION IV: SPECIAL PURCHASES / MODIFICATIONS

Description of Work / Purchase: List all one-time purchases, modifications or services you intend to buy through your Cash Management Plan. This includes all contractual work (modifications) you plan for your home.

Contractor / Provider Name: Indicate the name of the contractor or provider you intend to use for the work/purchase indicated.

Proposed Purchase Date: Indicate the month and year you expect to make each purchase listed.

Estimated Cost: Indicate the approximate total cost of each purchase listed above.

Estimated # of Monthly Payments: Indicate how many months it will require to pay for each purchase or modification listed.

Total Monthly Cost: Indicate the total monthly cost for each purchase or modification listed. (This figure should represent the estimated cost divided by the estimated # of monthly payments). This number indicates the amount of the monthly payment(s).

Total Monthly Special Purchase/Modification Costs: Indicate the sum of the total monthly cost for all expenses listed above under this section.

SECTION V: FISCAL INTERMEDIARY SERVICES & FEES

Description of Services and Fees: Indicate the type(s) of service(s) provided by the Fiscal Intermediary Service Organization (for instance, background investigation fees, employee health insurance fees, etc.).

# of Units: Indicate the number of units to be charged to your grant for each type of fee that is used.

Unit Cost: Indicate the unit cost for each fee type that is used. This information can be obtained by contacting the Fiscal Intermediary Organization.

Total Monthly Cost: Indicate the total monthly expense for each fee type by multiplying the number of units times the unit cost.

Total Monthly Fiscal Intermediary Costs: Indicate the sum of the total cost for all expenses listed above by adding them together to obtain the Total Monthly Fiscal Intermediary Expenses.

RECONCILIATION OF MONTHLY CASH BENEFIT

A. Total Monthly Cash Benefit: Indicate the amount of your total monthly budget as identified on page one of your Cash Management Plan.

B. Direct Employment Expenses: Indicate the total amount of expenses for the workers that you are employing directly.

C. Agency Purchase of Service Expenses: Indicate the total amount of expenses for services that you are purchasing through agencies.

D. Miscellaneous Expenses, Special Purchases/Modifications: Indicate the budgeted amount of the cash grant that is set aside for future one-time purchases, modifications, or for cash.

E. Fiscal Intermediary Expenses: Indicate the total amount of expenses for bookkeeping and other business related costs under the Fiscal Intermediary.

MONTHLY BALANCE: Subtract the expenses listed in B, C, D, and E, from the Total Monthly Cash Benefit (A) amount indicated above. In completing this calculation, your Monthly Balance should be as close to "0" as possible without having a negative balance. Any extra funds will be kept in your account.

Please sign, or ask your representative to sign and date your Cash Management Plan.

Carefully review the Cash Management Plan for accuracy and return it to your Consultant for review. Your Consultant will then complete and sign that the Cash Management Plan was reviewed, and will send it to the State Program Office for signature and approval.

The State Program Office will call you if they have any questions.

CRITERIA FOR USES OF CASH BENEFIT

The following items are allowable under the Personal Preferences Program:

Purchase of services from individuals, including family members.

Background checks and benefits for employees.

Purchase or increase in rental or homeowner's insurance, or other liability insurance as it relates to participant's role as employer.

Adult Day Care

Caregiver training and education which enables the caregiver to deliver home care with high levels of quality. May be purchased from a variety of sources, including a home care agency or a vocational or technical school.

Chore Services. This includes outside chores that provide for a safe environment and access in and out of the home.

Cleaning Service from firms or individuals.

Food preparation and delivery of prepared foods.

Transportation services not currently paid for under Medicaid.

Laundry service from a Laundromat or other provider.

Errand service to assist with banking, shopping and other types of routine tasks.

Home modifications such as ramps and grab bars, installation of visual or tactile alarms as well as wander alarms and other modifications not currently paid for by Medicaid.

Respite services to relieve unpaid caregivers.

Supplies and equipment that promote or enhance independence that are not currently paid for by Medicaid.

Services Not Authorized For Payment With Cash Management Plan without State review.

Food.

Entertainment equipment or supplies such as videos, VCR's, televisions, stereos CD's.

Illegal drugs or alcohol.

Travel for vacations or entertainment.

REPRESENTATIVE SELF-SCREENING QUESTIONNAIRE

New Jersey Department of Human Services
State Office on Disability Services
Personal Preference Program
(New Jersey Cash & Counseling Demonstration)

Representative Screening Questionnaire

Name of Participant:_____

Medicaid #: _____ Phone #: (_____)_____

Name of Potential Representative: _____

Address: _____

Phone #: (_____)_____ Relationship:_____

Are you a: family member_____ friend_____ legal guardian_____ of the above named participant in the Personal Preference Program?

If you are not a family member, please describe your relationship and how often you have contact with the participant:_____
_____
_____
_____

Do you receive money from the participant or anyone else to care for the participant?
Yes: _____ No: _____

If so, from whom, and for what purpose?_____
_____
_____

After reading the description that outlines the responsibilities of the representative, do you understand your functions and are you willing to volunteer to serve as the participant's representative? Yes: _____ No: _____

Are you willing to sign a designation form stating that you will serve in this capacity?
Yes: _____ No: _____

Do you understand that you cannot pay yourself in this role?
Yes: _____ No: _____

If you have any questions, please ask the consultant or call (toll free), 1-888-285-3036 before signing the designation form.