

**FISCAL INTERMEDIARY RESPITE PROGRAM
EMPLOYMENT AGREEMENT**

EMPLOYER(Consumer/Parent or Guardian)

EMPLOYEE (Respite Provider)

Adult/Child Consumer Name: _____

SSN: _____

Parent/Guardian Name _____

Date of Birth: _____

Address _____

Name : _____

Address: _____

The employee recognizes that employment is based on the employer's participation with C.E.I. Community Mental Health Respite Program:

The Employee (Respite Provider) agrees:

1. That this is an "at will" employment relationship, which can be terminated at any time.
2. That although a third party called a "fiscal intermediary" will draft my paycheck; they are only acting as a financial administrator and are not my employer.
3. To hold the "fiscal intermediary" harmless for their role as the financial administrator.
4. That the C.E.I. Community Mental Health Service's role is that of project administrator and that they are not my employer.
5. To hold C.E.I Community Mental Health Services harmless for their role as the project administrator.
6. To keep records indicating the extent of respite care or community living services provided.
7. On request, to furnish any records regarding services provided and payments received to C.E.I. Community Mental Health Services, the State of Michigan, and/or federal Medicaid agencies.
8. To follow the training specific to the child/adult as provided by the responsible relative/guardian and to report on activities performed.

The Employer (Parent/Guardian) agrees:

1. To pay my employee in the following manner: _____ per hour and/or _____ per day and/or other as described: _____
(When paying respite providers, there is a \$100.00 maximum daily charge and \$10.00 maximum hourly charge. i.e. 5 hours = \$50.00, 10-24 = \$100.00)
2. Provide C.E.I Community Mental Health Services with the necessary documentation to assure timely compensation of my employee.
3. To provide the employee with training specific to the care of my adult/child receiving respite.
4. To assure that my employee meets the requirements of the Respite Care Provider as listed on the Respite Program Basic Fact Sheet.

Employer (Parent/Guardian) Signature Date

Employee (Respite Provider) Signature Date

For Office Use Only

Consumer # _____

Date Faxed: _____