

# Personal Care Attendant Signature Form



THE COMMONWEALTH OF MASSACHUSETTS  
Executive Office of Health and Human Services

\_\_\_\_\_  
Name of fiscal intermediary (FI)

**All PCAs hired by the PCA consumer must complete and sign this form and give it to their employer (the PCA consumer) for submission to the fiscal intermediary (FI), and include all other paperwork required by the FI. The FI cannot pay the PCA until all required paperwork is received and complete. Please note that MassHealth and the FI cannot pay PCAs to work during the time the consumer is in an inpatient facility, such as a hospital or nursing facility, or if the consumer does not have a sufficient number of units on the prior-authorization request from MassHealth.**

I agree to accept the position of personal care attendant (PCA) for \_\_\_\_\_ .  
Employer (PCA consumer)

I have read or had explained to me the duties and responsibilities of a personal care attendant and agree to perform those duties and responsibilities during the hours designated by the PCA consumer. I understand that my employer is the PCA consumer, who may be required to designate a surrogate to assist my employer in managing the PCA program. I understand that I must notify my employer and my employer's surrogate, if any, of any changes in my circumstances that would affect my ability to perform my duties as a PCA.

I understand that I must complete and provide accurate Activity Forms (time sheets) in a timely fashion, and that, 1) the FI will deposit my check into my bank account if I have requested direct deposit, or 2) the FI will send my paycheck to my employer (the PCA consumer), who is responsible for giving the check to me. I agree to provide proof of my identity to my employer to complete the Employment Eligibility Verification form (Form I-9) that the Department of Homeland Security requires all employees to complete. (The FI will give my employer this form.)

I understand that providing false or misleading information to my employer (the PCA consumer), my employer's surrogate, the FI, the personal care management agency, or MassHealth may be considered fraud and may result in a referral to the Office of the State Auditor's Bureau of Special Investigations (BSI) or to the Office of the Attorney General.

I understand that I cannot be paid as a PCA if I am my employer's (the PCA consumer's) spouse, parent (if the PCA consumer is a minor child), surrogate, foster parent, or legally responsible relative.

The following represents my relationship to my employer (the PCA consumer). **(Please check one.)**

- |   |  |
|---|--|
| <input type="checkbox"/> adult (18 yrs. or older) child of consumer | <input type="checkbox"/> daughter-in-law of consumer                 |
| <input type="checkbox"/> son-in-law of consumer                     | <input type="checkbox"/> parent of adult (18 yrs. or older) consumer |
| <input type="checkbox"/> other relative (describe)                  | <input type="checkbox"/> non-relative (describe)                     |

\_\_\_\_\_  
I hereby state that I understand my duties, rights, and responsibilities as a PCA and that all the information I have provided to my employer (the PCA consumer) and to the FI is true and accurate to the best of my knowledge.

**Print PCA Name** \_\_\_\_\_

**PCA Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Employer (PCA consumer), surrogate, if applicable  
or legal guardian signature**

\_\_\_\_\_

**Date** \_\_\_\_\_