Personal Care
Job Seeking Agreement

(Agreement to be completed before member begins job seeking.)

Name: _____SSN:_____

Medicaid Number: _____ Date:_____

Provider Number: _____

Name/Title of Person Monitoring Plan: _____

Plan Dates: From: _____ To: _____

(*Check all applicable categories*)

_____I agree to register and maintain active status with my local Workforce WV AND one of the following:

□ **Individual Job Search**

I agree to:

1) Contact Workforce WV when notified of an opening and appear for interviews as schedule.

2) Contact_____(number) of potential employers per month and record results of an employer contact summary sheet to be reviewed by the agency every three months.

3) Contact at least one half of the employers in person. Or

4) other: ***(Please describe)***

_____

_____

□ **Vocational Rehabilitation Services from the Division of Rehabilitation Services**

I agree to:

1) Make application at the local Division of Rehabilitation Services Office;

2) Provided documentation of eligibility for Vocational Rehabilitation Services;

3) Provide documentation of continued participation in DRS Vocational services to this agency every three months.

□ **Participation in a Social Security (Ticket- to -Work) Employment Network**

I agree to:

I) Participate in a TWWIIA Employment Network Program;

2) Provide documentation of eligibility for a TWWIIA Employment Network Program;

3) Provide documentation of continued participation in the Social Security (Ticket- to -Work) Employment Network to this agency every three months. *(This option is not available at this time.)*

Job Seeking Agreement: I understand that personal care services will be provided outside the home when I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am seeking employment or partially employed, working less than forty (40) hours per month. I agree to adhere to the Job Seeking Agreement and to inform my provider agency of any change in my job seeking status. My provider agency will monitor the Job Seeking Agreement and maintain record of the Agreement in my Medicaid file for review by the Bureau for Medical Services.

Member's Signature:_____ Print Name: _____

Agency Name:_____

Signature:_____ Date:_____