PA-114
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South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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South Dakota Medicaid Temporary Exemption to Allow Family Members to Provide PDN Services Form

Parent Section

Name of Child: _____ Medicaid #: _____

Name of Parent (s): _____

Nursing License: ☐ **RN** ☐ **LPN** (check box)

Last work position including hours (full-time vs part-time, shift type, average hours per week (if not full-time time): **From:** _____ **To:** _____ **(**mm/dd/yyyy)

Ongoing work (include hours and/or schedule) _____

Other children in the home? ☐ Yes ☐ No

If yes, what is the Care Plan for children during PDN working hours?

Agency Section

Attempts made to staff with non-parent PDN and reason(s) for difficulty staffing (if known).

Please describe:

Any unique care needs for the child?

Rules and Oversight

- Hours are only authorized when the other parent/caregiver is not home or home with other responsibilities (such as remote work or care for other children in the household).
- Maximum of 40 hours per week. No rest hours. No travel hours. Only working hours are eligible.
- Family member working as a nurse must be treated the same as other employed nurses with regards to rules/responsibilities, including, but not limited to:
  - Should not be permitted to sleep/rest during paid hours
  - Should not have additional responsibilities during paid hours, including care of other children in the home or performing other job duties.
- The parent/caregiver is not eligible for payment when cancelling a scheduled nurse to accept a shift themselves and shall accept other qualified nurses placed by the agency, subject to reasonable objections or concerns.
- Office staff audits 100% of their charting to ensure there are no gaps, issues.
- The agency should perform supervisory visits occurring within the first 30 days, and every 60 days thereafter (Other in-person visits made can count if evaluating for adherence to rules above is part of the visit).

Parent:

I, _____ (Parent(s) Name), ATTEST THAT I WILL ABIDE BY THE ABOVE OVERSIGHT RULES

_____

Parent/Guardian Signature Date Parent/Guardian Signature Date

Agency:

I, _____ (Agency Name), ATTEST THAT I (We) WILL ABIDE BY THE ABOVE OVERSIGHT RULES

_____

Agency Signature Date

For renewals, please attach documentation for oversight in the last 6 months