MEMORANDUM OF AGREEMENT between the
Directly Observed Therapy (DOT) Aide and the Alaska TB Program

1. The DOT Aide will read the **Alaska DOT Manual** and acknowledge review of these training materials before administering DOT medications to patients. Each new DOT Aide will receive a one-time payment of $25 for completing the training. If a DOT Aide is providing DOT to multiple patients, only one payment of $25 is allowed per DOT Aide.

2. The DOT Aide will perform all duties and responsibilities outlined in the *DOT Aide Job Description*. This includes: ensuring safe and child proof storage of all medications; asking about side effects and stopping medications as instructed; notifying the PHN Case Manager if the patient does experience side effects or misses doses; watching the patient swallow each dose of medications; maintaining the patient's confidentiality; recording all doses on the *Monthly DOT Calendar* daily*;* and maintaining regular contact with the PHN Case Manager.

3. The DOT Aide will complete and mail or FAX a *Monthly Invoice for Payment* and a *Monthly DOT Calendar* to the PHN Case Manager after the last day of each month in which the Aide provides the patient with DOT services.

4. The DOT Aide will receive payment for their services once per month from the Alaska TB Program. This process takes up to 4 weeks from the time that the PHN sends the DOT Aide's approved *Monthly Invoice for Payment* and *Monthly DOT Calendar* to the Alaska TB Program.

5. Direct Deposit of funds into the DOT Aide's bank account is an option that makes payment faster. To request this, DOT Aides will need to complete and submit the *Electronic Payment Agreement* with the first invoice and calendar. Electronic payment requests take at least 1 billing cycle for processing.

6. The Alaska TB Program cannot guarantee the amount of work involved for each patient's care. The amount of work will vary depending on the patient's needs.

7. Job duties and responsibilities are described in the *DOT Aide Job Description* (see attached).

AGREEMENT

I, _____, _____, agree to provide tuberculosis medicines to
Name of DOT Aide Social Security #

_____, _____, of _____,
Name of Patient HR # Name of Village

Alaska for a period of time and according to directions specified by the patient's health care provider and the PHN Case Manager.

I understand I will be paid **$10.00** for each day I observe administration of TB medicines.

Signature of DOT Aide: _____ Date: _____

Signature of PHN Case Manager: _____ Date: _____

Signature of Alaska TB Program: _____ Date: _____