

INDEPENDENT CHOICES PARTICIPATION AGREEMENT

Participant Responsibilities

I have been informed about the Independent Choices Program (ICP) and I agree to:

Health and Well being

- Keep my living situation stable;
- Manage my money so that my food, shelter, and personal care needs are met and;
- Hire and maintain an employee provider.

Enrollment

- Complete the following forms: Independent Choices Program Employee Provider(s) Information (548), Workers Compensation Consent and Agreement (353).

IC Cash Benefit

- Use my ICP cash benefit for the sole purpose of paying providers via a check, purchasing items and services that enhance my independence and maintain or improve my health and well being. If I am not sure that an item meets these criteria, I will check with my case manager;
- My ICP cash benefit will not be used for illegal purposes and;
- Designate all ICP funds for use in a prior approved monthly budget.

IC bank account

- Keep a separate ICP checking account;
- Not overdraw my ICP account;
- Not commingle ICP cash benefits with other assets;

- Ensure the ICP cash benefit is directly deposited to this account and;
- Deposit my service liability (if any) into the ICP account monthly.

Bank records

- Make my bank records available to the Department of Human Services (DHS), Aging and People with Disabilities (APD) and Area Agency on Aging (AAA), only if requested

Payroll and taxes

- Pay my employees and payroll taxes timely from my ICP checking account. If my spouse or parent or other exempt provider is my employee provider, we may not need to pay, payroll taxes. If I do not pay the taxes, I will return this portion of my cash benefit to the local APD/AAA office. I understand I can employ a bookkeeper or pay an accounting service to assist me with these duties;
- Keep records of payments made for all employees;
- Make my payroll records available to the local APD/AAA office upon request and;
- Submit yearly WBF (Worker benefit funds) for myself and my employee(s).

Employee Providers

- Locate, screen, hire, fire, supervise, train my employees;
- Ensure my proposed provider is capable of completing the tasks they are assigned and meeting my needs based on the training they have received;
- Make sure my employees have had a criminal history check conducted by DHS;
- Pay my employees according to an agreed upon work schedule and wage and;

- Inform my case manager when a provider changes or their wage changes.

Back-up plan

- Develop and maintain a written individualized back-up plan in case of emergencies

Representative

I understand;

- I may choose or be required to have a representative to ensure that I am successful with the ICP requirements. If the representative doesn't fulfill the role, then I must choose another representative or I will be disenrolled. I have chosen (print name) _____ as my representative to fulfill my duties and responsibilities

Eligibility

- If I am no longer eligible for ICP I have a right to have a hearing. I can request a hearing based on Oregon Administrative Rule 461-025-0310. I also understand I can be involuntarily disenrolled based on Oregon Administrative Rule 411-030-0100.

Withdrawal and disenrollment from ICP

- My participation in ICP is voluntary and I may withdraw from the ICP program at any time. I may request an alternate Medicaid service option of my choice, including a Medicaid long term service plan but must meet all eligibility requirements;
- If I am disenrolled for any reason I must return any remaining ICP funds to the Department of Human Services within 30 days and;
- If I am disenrolled for any reason I may not re-apply for ICP for six months. After the disenrollment period, I may request ICP

but must meet all eligibility requirements at the time of the new request.

Absent from the home

- If I am absent from my home for longer than 30 days due to illness or medical treatment, the ICP cash benefit will be terminated

I agree to follow all the ICP program requirements as stated in OAR 411-030-0100. I understand if I do not follow these requirements then I will be involuntarily disenrolled from the program.

By signing this statement, I agree to these terms and conditions. I understand and accept the risks and responsibilities of the Independent Choices Program and want to enroll.

Print Participant's name _____

Participant's Signature _____

Date _____