

INDEPENDENT CHOICES REPRESENTATIVE AGREEMENT

I agree to act as a representative decision-maker for: (print name)
_____, who is a participant in the
Independent Choices Program (ICP). I have been informed about the
Independent Choices Program and I agree to:

Health and Well being

- Keep the living situation stable;
- Manage the IC money so that the food, shelter and personal care needs of the participant are met and;
- Hire and maintain an employee provider(s) to work for the participant.

Enrollment

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

IC Cash Benefit

- Use the participant's ICP cash benefit for the sole purpose of paying provider(s), purchasing items and services that enhance the participant's independence and maintain or improve their health and well being. If I am not sure an item meets these criteria, I will check with the case manager;
- Use the ICP cash benefit for legal purposes only and;
- Designate all ICP funds for use in a prior approved monthly budget.

IC bank account

- Have my name added to the participant's ICP checking account immediately upon appointment as the representative;

- Not overdraw this account;
- Not commingle ICP cash benefits with other assets;
- Ensure the ICP cash benefit is directly deposited to this account;
- Ensure the participant's service liability (if any) is deposited into this account monthly and;
- Pay the participant's providers, service costs and payroll taxes from this account.

Payroll and taxes

- Assure all employer withholdings, employer tax records including W-2's, copies of 1040's, copies of payment of FICA, FUTA and SUTA taxes are updated and available to the local APD/AAA office upon request;
- Calculate the employee's payroll taxes and pay them on time;
- Return any unused portion of the payroll taxes provided by the state as the employer's share of FICA, FUTA and SUTA to the local APD/AAA office if applicable and;
- Return to the employee any portion of their FICA tax that was withheld from paychecks but not owed at the end of the tax year.
- Ensure yearly WBF (Workers benefit fund) is submitted for the participant and their employee(s).

Employee Providers

I agree to:

- Report to the Case Manager any concerns regarding the employee provider(s) capability to complete the tasks and meet the needs of the participant;
- Ensure all employee provider(s) complete a criminal history check. Depending on the results of the final fitness determination the participant may or may not hire this person as an employee provider;

- Assist at the participant's request to hire, fire, train, supervise, develop a job description, develop a work schedule, track the hours worked and pay the providers according to an agreed upon schedule;
- Keep correct records of employee hours worked and make the records available to the local APD/AAA office upon request and;
- Assist with informing the case manager when a provider changes or their wage changes.

Eligibility

- My participation in ICP is voluntary, and I cannot be required to participate in the program;
- As a volunteer I cannot accept any payment for services or assistance to a participant in the ICP program. I can not use my role as a representative for personal gain and;
- Submit to a criminal history check. I understand that I must receive a final fitness determination of approval or I will not be allowed as a representative.

Withdrawal and ineligibility in ICP

- APD/AAA may decide the participant is no longer eligible to participate in the ICP or that I am no longer eligible to participate as a representative. My ineligibility may be based on my failing to fulfill the terms and conditions of the participation agreement based on Oregon Administrative Rule 411-030-0100;
- I may end my participation as a representative in the program after giving the local APD/AAA office 30-days notice. I will also remove my name from the ICP bank account. If this should occur, the participant may name another person as a representative or select an alternate Medicaid service option of their choice if they are eligible for other service options and;
- If the participant is disenrolled for any reason I will assist in returning any remaining ICP funds to the Department of Human Services within 30 days.

Absent from the home

- If the participant dies, moves to a hospital, a nursing home, an adult foster home, a residential or assisted living facility for more than 30 days, I will return any money which has accumulated in the ICP bank account to the local APD/AAA office.

I agree to follow all the ICP program requirements as stated in OAR 411-030-0100 and if I do not follow these requirements than I will be ineligible for the program.

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

I understand that when I am no longer a representative due to the death of the participant, ineligibility or a change in the representative, all ICP program funds including the bank account and items purchased by the participant with ICP money do not belong to me, and need to be released to the participant or Department of Human Services.

Print Representative's Name _____

Date _____

Representative's Signature _____

Address _____
