DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Independent Choices Participation Agreement

Participant responsibilities

I have been informed about the Independent Choices Program (ICP) and I agree to the rules below.

Health and well-being

I agree to:

- 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

I will complete the following forms:

- Independent Choices Program Employee Provider(s) Information (SDS 0548); and
- Workers Compensation Consent and Agreement (SDS 0353).

IC cash benefit

I understand:

- I can only use my ICP cash benefit for:
  - Paying providers with a check;
  - Buying items and services that help me be more independent 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 can't be used for illegal purposes; and
- I must use my ICP funds according to a pre-approved monthly budget.

IC bank account

I will:

- Keep a separate ICP checking account;
- Not overdraw my ICP account;
- Not commingle ICP cash benefits with other assets;
- Make sure my ICP cash benefits are deposited directly into my ICP checking account; and
- Deposit my service liability (if any) into the ICP account each month.

Bank records

I will make my bank records available to the Department of Human Services (DHS), Aging and People with Disabilities (APD) and Area Agency on Aging (AAA), if requested.

Payroll and taxes
I will:
- Pay my employees and payroll taxes from my ICP checking account on time;
  - If my spouse, parent or other exempt provider is my employee provider, we may not need to pay payroll taxes.
  - 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, if requested;
- Submit yearly WBF (worker benefit funds) for myself and my employee(s).

Employee providers
I will:
- Locate, screen, hire, fire, supervise and train my employees;
- Make sure my chosen provider is capable of doing 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 a work schedule and wage we agreed on; and
- Inform my case manager when a provider or their wage changes.

Back-up plan
I will develop and maintain a written, individualized back-up plan in case of emergencies.

Representative
I understand:

- I may choose to or be required to have a representative to make sure 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 ______________________ as my representative to fulfill my duties and responsibilities.

Eligibility
I understand that 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
I understand:
- 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 I 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 I must meet all eligibility requirements at the time of the new request.

Absent from the home
I understand that 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 that if I do not follow these requirements, 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: ______________________________

You can get this document in other languages, large print, braille or a format you prefer. Contact at or email . We accept all relay calls or you can dial 711.