INDEPENDENT CHOICES REPRESENTATIVE AGREEMENT

Representative Responsibilities

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

Health and Well-Being

- Keep the living situation stable;
- Manage the ICP 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 and sign 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 providers via a check from their ICP checking account, 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.

ICP Bank Account

- Have my name added to the participant's ICP checking account immediately upon appointment as their representative;
- Not overdraw the ICP checking account;
- Not commingle ICP cash benefits with other assets;
- Ensure the ICP cash benefit is directly 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. If I am not required to pay taxes to an employee, I will keep that money in the ICP checking account to be used for future employee wages or contingency/discretionary funds until such time that the participant's ICP benefit ends;
- Calculate the employee's payroll taxes and pay them on time;
- 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; and
- 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 rate and schedule;
- Keep correct records of employee provider(s) 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 when their wage changes.

Eligibility

- My participation is the 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 participate in the ICP. 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.

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Withdrawal and Ineligibility in the ICP

- APD/AAA may determine 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 or the Participation Agreement based on Oregon Administrative Rule 411-030-0100;
- I may end my participation as a representative in the ICP after giving the local APD/AAA office a 30-day notice. I will also remove my name from the ICP bank account immediately should this 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 local APD/AAA office within 30 days.

Absent from the Home

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

I agree to follow the ICP requirements as stated in OAR 411-030-0100 and if I do not follow these requirements, I will not be allowed to continue as the participants representative.

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 the representative due to the death or the participant, ineligibility or a change or a representative change, all ICP funds including the bank account and items purchased by the participant or myself with the ICP money does not belong to me and must be released to the participant or the Department of Human Services.

Print Representative Name: _____

Date: _____

Representative Signature: _____

Representative Address: _____