Oregon Independent Choices Program (ICP)

Employee Agreement

Name of Participant (please print) _____

Name of Employee (please print) _____

Employee Address _____

_____

Employee Gender _____ **Employee Phone** _____
Male/Female

Employee Email _____

- ☐ ***None***, no relation to employer
- ☐ ****Spouse*** of the employer,
- ☐ ****Child*** of the employer and under the age of 21
- ☐ ****Parent*** of the employer - if this option is marked, read below and check all that apply:
  - ☐ ***You are employed by your son or daughter***
  - ☐ ***Your son or daughter has a child or stepchild living in the home***
  - ☐ ***Your son or daughter is a widower, divorced, or is living with a spouse who, because of a mental or physical condition, cannot care for the child or stepchild for at least 4 continuous weeks in a calendar quarter***
  - ☐ ***Your son or daughter's child or stepchild is under the age of 18 and requires the personal care of an adult for at least 4 continuous weeks in a calendar quarter due to a mental or physical condition***

*Internal Use Only
• If Parent (employee) selected all 4 parent conditions, parent/employee is **FUTA and SUTA Exempt** • If Parent (employee) did **NOT** select all 4 parent conditions, parent/employee is **FICA, FUTA, SUTA Exempt**
• If Spouse or Child are selected, employee is **FICA, FUTA, SUTA Exempt**

The employee agrees to accept payment for services provided for individuals served through Oregon's Independent Choices Program. Financial Support Services are provided by Acumen Fiscal Agent, LLC, which is not an Oregon government agency. Acceptance and endorsement of payment will signify that the employee agrees to the following terms and conditions:

1. I understand and acknowledge that the participant or the participant's representative is my employer. My employer is not Acumen, the State of Oregon, Oregon Department of Human Services (OR DHS), Seniors and People with Disabilities (SPD) or any other entity involved with this Independent Choices Program.
2. I accept payment as payment in full for the services provided. I cannot accept any additional compensation for the hours I have worked.
3. I will provide only the services that have been approved by my employer and authorized in the participant's Service Budget.
4. I understand I will be required to accurately complete and submit my time worked through the Acumen DCI/Web Time Entry (WTE) portal or Mobile App on a timely basis, as outlined in the Payment Schedule provided to me. I understand that failure to submit my time worked on time will result in the delay of compensation for the hours I have worked.
5. I will provide OR DHS/APD or its designee information regarding the service(s) provided for which payment was made, upon request.

6. I recognize that employment is dependent on the participant's participation in the Independent Choices Program.
7. I will immediately notify a person designated by the employer of any participant medical emergency, illness, or visit to a physician.
8. I will take part in any meetings if requested by and/or regarding the participant.
9. I understand and consent to having a Medicaid List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED) background check completed on me. I understand that my employment is contingent on the results of this check in accordance to all applicable laws, rules and policies.
10. I agree to complete all required paperwork and be approved prior to providing any services under the Independent Choices Program.
11. I understand that I may have access to confidential information about the participant and that I am not to repeat this information to anyone other than the participant or the participant's designee.
12. I understand and acknowledge that any untruthful submission of services provided in an attempt to obtain improper payment is subject to investigation as fraud.
13. I understand that I am required to report the abuse or neglect of any individual participating in the Oregon Independent Choices Program to the participant's case manager.
14. I acknowledge that I have the necessary skills, knowledge and experience; and have received sufficient training and orientation to meet the support needs of the participant. I will inform my employer if I feel I need more orientation and/or training to meet the support needs of the participant.

By signing below, I acknowledge that I have read this employee agreement in its entirety (2 pages). I understand that I must sign and return both pages as a condition of employment in this program and that I cannot begin working in this Independent Choices Program until this form is completed and returned to Acumen Fiscal Agent. I further acknowledge by signing below, that I understand what is being required of me, and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and/or conditions of this agreement may result in termination of this agreement and payment for employment to any recipient of this program.

Employee Signature *Date*

Participant/Employer or Representative Signature *Date*