

Independent Choices Program (ICP) Participation Agreement

Updated: April 13, 2026 (template update only-no content changes)

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
- Hire and maintain an employee provider

Enrollment

I will complete the following forms:

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

ICP 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
- I must use my ICP funds according to a pre-approved monthly budget.

ICP bank account

I will:

- Keep a separate ICP checking account
- Not overdraw my ICP account
- Not co-mingle ICP cash benefits with other assets
- Make sure my ICP cash benefits are deposited directly into my ICP checking account

Bank records

I will make my bank records available to the Oregon Department of Human Services (ODHS), 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 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 Workers' Benefit Fund (WBF) Assessment fees no less than yearly for myself and my employee(s)

Employee providers

I will:

- Locate, screen, hire, fire, supervise and train my employee(s)
- Make sure my chosen provider is capable of doing the tasks they are assigned and are meeting my needs based on the training they receive
- Make sure my employee(s) have had a criminal history background check conducted by ODHS
- Pay my employee(s) according to the work schedule and wage we agree on
- 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.

ICP representative

I understand:

- I may choose to or be required to have an ICP representative to make sure I am successful with the ICP requirements. If the representative does not fulfill the role, I must choose another ICP representative or I may be disenrolled from ICP. I have chosen _____ as my ICP representative to fulfill my employer duties and responsibilities.

Eligibility

I understand that if I am no longer eligible for ICP, I have the right to request a hearing. I can request a hearing based on Oregon Administrative Rule 461-025-0310. I also understand I can be involuntarily disenrolled from ICP 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 ICP 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 ODHS within 30 days
- If I am disenrolled for any reason, I may not be able to 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.

Agreement

I agree to follow all ICP requirements as stated in Oregon Administrative Rule 411-030-0100. I understand that if I do not follow these requirements, I may 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 ICP 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 free of charge. Contact the Aging and People with Disabilities at apd.ltss@odhs.oregon.gov or [503-945-5600](tel:503-945-5600). We accept all relay calls.

Aging and People with Disabilities

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