| Participant | Participant PPL ID # | Provider |
|---|---|---|
| | | |

**FORM B**

# Participant and Employee Terms of Agreement

*(NOTE: One agreement must be completed per participant)*

Please indicate which DDS Program the Participant is enrolled in:

| WAIVER PROGRAM | STATE PROGRAM | STATE PLAN |
|---|---|---|
| ☐ Adult Support | ☐ Adult Support | ☐ State DD |
| ☐ Community Living Supports | ☐ Community Living Supports | |
| ☐ Residential | ☐ Residential | |

**Please review the following to ensure the form is completed correctly:**

1. List the service(s) below which you are applying to provide. Include all applicable services from the list below and the specific negotiated rate for the service(s) shown.
2. Verify that the rate of pay is listed below. For employee (IP) services, PPL will automatically calculate the billable rate to the participant's budget based upon the pay rate listed below.
3. The **Employee Wages: Cost to You** document, located on https://www.publicpartnerships.com, will help you determine what the billable rate will be based on the pay rate agreed upon below.

| SERVICE | UNIT TYPE | START DATE | RATE |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |

| ADULT SUPPORTS | | | COMMUNITY LIVING SUPPORTS | | | RESIDENTIAL | | |
|---|---|---|---|---|---|---|---|---|
| *Code* | *Unit* | *Description* | *Code* | *Unit* | *Description* | *Code* | *Unit* | *Description* |
| 5168 | Hour | Supported Employment | 5168 | Hour | Supported Employment | 5168 | Hour | Supported Employment |
| 5196 | Trip | Transportation Trip Rate | 5196 | Trip | Transportation Trip Rate | 5196 | Trip | Transportation Trip Rate |
| | | | 5705 | Hour | Respite – In Recipient's Home | 5705 | Hour | Respite – In Recipient's Home |
| | | | 5703 | Hour | Individualized Home Supports | 5156 | Day | 24 Hr. Self-Directed Home Sharing |
| | | | 5704 | Hour | Individualized Day Supports | 5157 | Day | 24 Hr. Self-Directed Home Sharing |
| | | | 5707 | Hour | Adult Companion | 5158 | Day | 24 Hr. Self-Directed Home Sharing |
| | | | 5725 | Hour | Chore | | | |

| Participant | Participant PPL ID # | Provider |
|---|---|---|
| | | |

# FORM B

Whereas, the DDS has identified ___________________________ as a “participant” who is eligible for the Participant Directed Program services and assistance, and whereas the participant, following a review of available choices, has selected _____________________________ as a provider who will provide the service(s) and supports listed from the above, consistent with the participant’s DDS Participant Directed Programs Individual Support Plan at a pay rate specified above.

Services will be provided starting __________________ and end on ________________________.

Employee Signature ____________________________________ Dated ______________________

Employee Name (Printed) ______________________________

Participant or Responsible Party Signature ________________________________

Participant Name (Printed) ______________________________ Dated ______________________

*This agreement will continue in full force and effect until the contract ends or is ended by the Participant if Public Partnerships still is the Financial Management Service for the DDS Participant Directed Program.*