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

**FORM B**

# Participant and Agency 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 |
|---|---|
| ☐ Adult Support | ☐ Adult Support |
| ☐ Community Living Supports | ☐ Community Living Supports |
| ☐ Residential | ☐ Residential |

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

1. 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.
2. 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.
3. 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.

| Adult Supports | | | Community Living Supports | | | Residential | | |
|---|---|---|---|---|---|---|---|---|
| *Code* | *Unit* | *Description* | *Code* | *Unit* | *Description* | *Code* | *Unit* | *Description* |
| 5168 | Hour | Supported Employment | 5168 | Hour | Supported Employment | 5196 | Trip | Transportation Trip Rate |
| | | | 5703 | Hour | Individualized Home Supports | 5705 | Hour | Respite – In Recipient's Home |
| | | | 5704 | Hour | Individualized Day Support | 5702 | Day | Respite – In Caregiver's Home |
| | | | 5707 | Hour | Adult Companion | 5707 | Hour | Adult Companion |
| | | | 5710 | Hour | Behavioral Supports and Consultation | 5704 | Hour | Individualized Day Support |
| | | | 5716 | Hour | Peer Support | 5710 | Hour | Behavioral Supports and Consultation |
| | | | 5725 | Hour | Chore | 5709 | Hour | Family Training |
| | | | 5709 | Hour | Family Training | 5289 | Hour | Assistive Technology Evaluation and Training |
| | | | 5180 | Hour | CIES – Competitive Employment | | | |
| | | | 5289 | Hour | Assistive Technology Evaluation and Training | | | |

| Service Description | Service Code | Unit Type | Start Date | Rate |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |

| 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 on _____ and ending on _____

| Agency Representative Signature | Agency Representative Name (Printed) | Date |
|---|---|---|

| Participant or Responsible Party Signature | Participant Name (Printed) | Date |
|---|---|---|

*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.*