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

**FORM B**

# Participant and Independent Contractors 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. 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* |
| 5198 | Unit | Transportation Mileage | 5704 | Hour | Individualized Day Support | 5704 | Hour | Individualized Day Support |
| | | | 5710 | Hour | Behavioral Supports and Consultation | 5710 | Hour | Behavioral Supports and Consultation |
| | | | 5716 | Hour | Peer Support | 5716 | Hour | Peer Support |
| | | | 5719 | Day | Live-in Caregiver | 5709 | Hour | Family Training |
| | | | 5709 | Hour | Family Training | 5282 | Hour | Personal Agent |
| | | | 5282 | Hour | Personal Agent Services | 5198 | Unit | Transportation Mileage |
| | | | 5198 | Unit | Transportation Mileage | 5702 | Hour | Respite – In Caregiver's Home |
| | | | 5289 | Hour | Assistive Technology Evaluation and Training | 5289 | Hour | Assistive Technology Evaluation and Training |
| | | | | | | | | |
| | | | | | | | | |

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

**FORM B**

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

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_____.

Independent Contractor Signature_____Date _____

Independent Contractor Name (Print) _____

Participant or Responsible Party Signature _____

Participant Name (Print)_____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.*