DHS Oregon Department of Human Services

Seniors and People with Disabilities

Information Memorandum Transmittal

Jeanette Burket
Authorized Signature

Number: **SPD-IM-10-069**
Issue Date: 9/7/2010

Topic: Long Term Care

Subject: Worker's Compensation Insurance for employee providers in the Independent Choices Program

Applies to (check all that apply):

- ☐ All DHS employees
- ☒ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☐ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Health Services
- ☒ Seniors and People with Disabilities
- ☐ Other (please specify):

Message:

Starting January 1, 2011 employee providers for Independent Choices Program (ICP) participants will be covered by worker's compensation. The Oregon Legislature passed House Bill 3618 during the February 2010 special session, the Governor signed the bill and it has now become law. However, in preparation, data must be collected regarding the current employee providers and their base wages.

House Bill 3618 relates to "Personal Support Workers" and defines them as employees hired by the client or the client's family or guardian and paid with public funds. In general, this new law covers people paid by the ICP participants via ICP who are now considered Personal Support Workers.

Since the participants of ICP are seen as the employer of a Personal Support Worker they and their employee provider(s) are subject to this newly enacted law.

Central office mailed a letter to all ICP participants who were enrolled as of August 18, 2010 on September 2, 2010, explaining the above information and requesting that they complete the Independent Choices Program

Employee Provider(s) Information form. The purpose of this form is to collect information about their provider(s), including their wages. For your information a copy of the letter and the form are attached.

Best practice for collecting this information after October 1, 2010 and on-going will be developed in conjunction with the SPD Operations Committee.

If you have any questions about this information, contact:

Contact(s):	Kelsey Weigel, In-home policy analyst		
Phone:	503-945-6413	**Fax:**	503-947-4245
E-mail:	Kelsey.C.Weigel@state.or.us		

September 2, 2010

To: Independent Choices Program participants

The Oregon Legislature passed House Bill 3618 during the February 2010 special session, the Governor signed the bill and it has now become law. The purpose of this letter is to make you aware of this new law and its importance to you and your employee provider(s).

House Bill 3618 relates to "Personal Support Workers" and defines them as employees hired by the client or the client's family or guardian and paid with public funds. In general, this new law covers people paid by you via the Independent Choices Program who are now considered Personal Support Workers.

As a person who receives services through the Independent Choices Program or as the employer of a Personal Support Worker, you and your employee provider(s) are subject to this newly enacted law. The new law creates several provisions that you need to be informed of.

1) Personal Support Workers will be covered by Workers' Compensation Insurance effective January 1, 2011. The Oregon Home Care Commission (OHCC) provides the coverage and administers the workers' compensation claims for personal support workers injured on the job. The OHCC pays the workers' compensation premiums on your behalf. You may have a minimal cost, $1 per month or less, on average.

2) Personal Support Workers will now have access to job related training provided by the OHCC beginning in January 2011. You will also receive information in 2011 about training opportunities being developed for you.

3) House Bill 3618 requires that the names and mailing addresses of Personal Support Workers be made available to individuals that may request it, subject to public records laws. Such requests may come from entities interested in organizing workers for the purpose of collective bargaining. So because of this new law, your employee provider(s) may be contacted for that specific purpose.

4) You will have additional responsibilities related to Workers' Compensation for your employee provider(s).
    a. If an employee is injured on the job, you will be required to provide 52 weeks of payroll information in a timely manner.
    b. You will need to provide monthly and quarterly information regarding payroll.
    c. Complete the enclosed Independent Choices Program-Employee Provider(s) information form and return it in the enclosed envelope.

As noted earlier, in the upcoming months, you and your Personal Support Workers will be receiving additional information on this important new law and how it affects you and your employees. In the meantime, please complete the enclosed form and return it in the self-addressed envelope by **September 16, 2010**. If you have questions about this letter or the enclosed forms, please contact Kelsey Weigel, the statewide Independent Choices Coordinator, at (503) 945-6413.

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
In-home Services

Independent Choices Program
Employee Provider(s) Information

Participant profile	
Name:	Date of birth:
Mailing address:	Phone number:
Physical address:	Case manager phone number:

Payroll information

Do you use a payroll service? ☐ Yes ☐ No If yes, please write the name of the service below:

Do you use payroll software like QuickBooks? ☐ Yes ☐ No If yes, please write the software program below:

If your employee is injured on the job, you will be required to provide 52 weeks of payroll information in a timely manner.

You will be required to provide payroll for the previous month by: _____

Employee 1 profile	
Name:	Social Security number:
Mailing address:	Date of birth:
Physical address:	Phone number:

☐ New hire Original hire date: _____

Hourly Wage Rate: (authorized amount before taxes) _____

Monthly Wage: (authorized amount before taxes) _____

☐ Provider change Start date: _____ End date: _____

Please check the types of services provided by this employee: Please see details for each of the areas on the back.

☐ Activities of daily living ☐ Self-management tasks

☐ Health related procedures ☐ Transportation

Regular scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S **OR**

☐ Hourly ☐ Live-in

Shift during work days: From: _____ ☐ AM ☐ PM To: _____ ☐ AM ☐ PM

Employee 2 profile

Name:	Social Security number:
Mailing address:	Date of birth:
Physical address:	Phone number:

☐ New hire Original hire date: _____

Hourly Wage Rate: (authorized amount before taxes): _____

Monthly Wage: (authorized amount before taxes): _____

☐ Provider change Start date: _____ End date: _____

Please check the types of services provided by this employee: Please see details for each of the areas on page 2

☐ Activities of daily living ☐ Self-management tasks

☐ Health related procedures ☐ Transportation

Regular scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S **OR**

☐ Hourly ☐ Live-in

Shift during work days: From: _____ ☐ AM ☐ PM To: _____ ☐ AM ☐ PM

Changes

Change	Payment amount	Old information	New information
☐ Monthly payment to employee 1			
☐ Monthly payment to employee 2			

List any other changes not listed above:

☐ Other change: _____

☐ Other change:

Please check all services that your employees provide.

*If a service is not included, please write-in the service in the "*Other" services provided.

Activities of daily living	**Employee 1**	**Employee 2**	**Transportation** *(Check all that apply.)*	**Employee 1**	**Employee 2**
Ambulation	☐	☐	**Drives your vehicle**	☐	☐
Bathing	☐	☐	**Escorts you on public transportation**	☐	☐
Bladder care	☐	☐	**Drives you in their car**	☐	☐
Bowel care	☐	☐	***Other:**	☐	☐
Cognition	☐	☐	***Other:**	☐	☐
Dressing	☐	☐	***Other:**	☐	☐

Feeding	☐	☐	***Other:**	☐	☐
Grooming	☐	☐	**Health related procedures**		
Personal hygiene	☐	☐	**Bowel program**	☐	☐
Positioning	☐	☐	**Feeding tube**	☐	☐
Toileting	☐	☐	**Home dialysis**	☐	☐
Transferring			**Injections**	☐	☐
***Other:**	☐	☐	**Ostomy care**	☐	☐
***Other:**	☐	☐	**Oxygen management**	☐	☐
***Other:**	☐	☐	**Range of motion or exercises**	☐	☐
***Other:**	☐	☐	**Suctioning**	☐	☐
***Other:**	☐	☐	**Tracheotomy care**	☐	☐
Self-management tasks			**Urinary catheter care**	☐	☐
Giving/setting up	☐	☐	**Ventilator care**	☐	☐
Housekeeping	☐	☐	**Wound care**	☐	☐
Laundry	☐	☐	***Other:**	☐	☐
Meal preparation	☐	☐	***Other:**	☐	☐
Shopping	☐	☐	***Other:**	☐	☐
***Other:**	☐	☐	***Other:**	☐	☐
***Other:**	☐	☐	***Other:**	☐	☐

(Employer signature) *(Date)*