iHPNetwork
Integrative Lifestyle Medicine

Medicare Diabetes Prevention Program
Lifestyle Coach Memorandum of Understanding

In order to ensure quality and compliance, iHealth Partners Network has established the following policies and procedures within this Memorandum of Understanding to establish a collaborative understanding between lifestyle coaches and iHPNetwork. Please sign on the bottom of page to indicate your acknowledgement and acceptance of these requirements and initial at the appropriate areas marked:

- In order to be qualified to provide lifestyle coaching for the National Diabetes Prevention Program under the requirements of the CDC and CMS, I understand that I must first attend and successfully complete a coach training conducted by trainers who are certified and authorized by iHPNetwork. I will actively participate in all aspects of the training. I understand that only approved trainers can teach others to become Lifestyle Coaches. I will not teach other coaches how to lead the DPP workshop.
- I understand that I must first be pre-screened by iHPNetwork to ensure that I have the appropriate qualifications before I can attend lifestyle coach training
- Before I can attend a iHPNetwork DPP training, I will pre-register and submit this signed Statement of Understanding. I will also receive written and/or verbal notification that I have been accepted into the training.
- I will request and process background checks and authorization forms as part of iHealth Partners Network credentialing process.
- I understand that I am an independent contractor and NOT an employee of iHealth Partners Network and
- I understand that I will receive $50 per session as a lead instructor. Payment will be processed once a month for lifestyle coaches.
  Please Initial:_____________________
- I will complete an additional approved HIPAA training to be paid for by iHPNetwork before facilitating a workshop. The HIPAA training will be scheduled by iHPNetwork or if already trained, it must be pre-approved by iHPNetwork.
- I understand and accept that the information I will be collecting is sensitive and confidential and will protect it accordingly. I will not disclose any personally identifiable information provided by iHPNetwork workshop participants. I will follow all standard safeguards for protecting this information, including storing in secured, locked locations; both physical and/or electronically.
  Please Initial:_____________________
- I will conduct a one-year long workshop. The first portion of the program consists of 16 one-hour weekly sessions, followed by 8-12 one-hour sessions that meet biweekly and then monthly. The workshop must begin within six months to one year of completing the training.
- I understand that if I terminate the relationship before one-year, I agree to pay the trainings that I received through iHPNetwork in the amount of $1,600.00 to be paid within 30-days of self-termination. If iHPNetwork terminates the relationship at any time, I understand that I am NOT responsible for reimbursement of my training fee.
  Please Initial:_____________________

- I under that I am NOT responsible for reimbursing my training fee if iHealth Partners Network does NOT provide me with at least one (1) one-year long workshop.
  Please Initial:_____________________
- If I or iHPNetwork decide to terminate the relationship, payment will be for completed sessions only.
  Please Initial:_____________________
- I agree to follow the standardized program curriculum of the CDC and CMS and will not make any variations in the approved program content described in the program leader manual without prior written permission. I will cooperate with fidelity monitoring as needed.
- I will not sell any products or additional services to participants.
  Please Initial:_____________________
- I agree to contact the iHealth Partners Network Diabetes Prevention Program Coordinator immediately if I am unable to deliver a scheduled workshop that I have committed to so that alternative arrangements can be made. I will not hire a subcontractor to deliver my program.
- I agree to participate in annual continuing education activities. I will also attend as many other meetings and participate in monthly conference calls as my schedule allows.
- I will conduct and support marketing efforts for the workshops in my community in collaboration with iHPNetwork. I will notify iHPNetwork of sites interested in offering the workshop.
- I will submit all required data to iHPNetwork within 24 hours of each session and review participant tracking sheets (or via iHPNetworks Electronic Care Plan) before the next session. Data must be received prior to payment being processed.
- I understand that I am responsible for all expenses incurred while performing services under this Agreement. This includes automobile, truck, and other travel expenses; vehicle maintenance and repair costs; vehicle and other license fees and permits; insurance premiums; road, fuel, and other taxes; fines; radio, pager, or cell phone expenses; and meals.
  Please Initial:_____________________
- I understand that iHPNetwork will not withhold FICA (Social Security and Medicare taxes) from my payments or make FICA payments on my behalf or make state or federal unemployment compensation or contributions on my behalf; or withhold state or federal income tax from my payments.
  Please Initial:_____________________
- I understand that I am NOT eligible to participate in any employee pension, health, vacation pay, sick pay, or other fringe benefit plan of iHealth Partners Network.
- I am aware of and understand that iHPNetwork shall not provide insurance coverage of any kind for me and I agree to obtain or provide proof of the following insurance coverage and maintain it during the entire term of this Agreement: Comprehensive or general liability insurance coverage in the minimum amount of $1,000,000 each occurrence/$3,000,000 aggregate - combined single limit, including coverage for bodily injury, personal injury, broad form property damage, contractual liability, and cross-liability.

- Before commencing any work, I shall provide iHPNetwork with proof of this insurance and with proof that iHPNewtwork has been made an additional insured under the policies.
  Please Initial:____________________
- **Indemnification:** As an independent Contractor I shall indemnify and hold iHealth Partners Network harmless from any loss or liability arising from performing services under this Agreement including personal injury or accident.

Waiver
I am agreeing to represent iHealth Partners Network as a Medicare Diabetes Prevention Program lifestyle coach as an independent contractor and will receive a 1099 -MISC form at the end of the year. No compensation or benefits other than the agreed upon compensation per delivered session will be paid. I agree that iHealth Partners Network may use my image for iHPNetwork displays, educational programs and/or other public relations, and I hereby release any such images/photographs for use in its programs, publications, and purposes.

I HAVE READ AND I UNDERSTAND THE PRECEDING STATEMENTS. I FURTHER UNDERSTAND THAT COMPLIANCE WITH THIS STATEMENT OF UNDERSTANDING IS REQUIRED FOR MY TRAINING AND CONTINUED PARTICIPATION AS A Lifestyle Coach.

Print Name of Applicant: ____

Date:____

Signature:____