DHS | Oregon Department of Human Services
INTELLECTUAL/DEVELOPMENTAL DISABILITIES

I/DD PERSONAL SUPPORT WORKERS ONLY

Personal Support Worker (PSW) Provider Enrollment Application and Agreement

(Revised 08/01/2018)

This Provider Enrollment Application and Agreement *(Agreement)*, sets forth the conditions and agreements for being enrolled as a Medicaid Personal Support Worker *(Provider)* with the State of Oregon Department of Human Services (DHS), Office of Developmental Disabilities Services (ODDS), and to receive a Provider number to receive payment for services furnished by the Provider to approved Medicaid eligible individuals *(Recipients)* in Oregon. Payments for services are made using federal Medicaid and state funds.

Type of action requested

☐ New enrollment ☐ Renewal or re-enrollment

Provider type requested *(mark all that apply)*

Note: All new and renewing providers will be enrolled as Personal Support Workers (84-803). Please only check those **additional** provider types which apply to your enrollment.

Legal name *(first name, middle initial, last name **as listed on your current SSN card**)*:

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☐ PSW Children Intensive In-Home Services (84-801)

☐ PSW State Plan Personal Care (84-800)

☐ PSW Employment Job Coach (84-809)*

*PSWs enrolling as a **Job Coach (84-809)** must have the appropriate training required in Oregon Administrative Rule (OAR) 411-345-0030 prior to enrollment and must submit training documentation with this application. Job Coach enrollment is good for two years only and must be renewed separately from this agreement.

Provider Information (Required)

- Disclosure of Social Security Number **is required** pursuant to 41 USC 405(c)(2)(C)(i) to establish identification, 42 CFR 455.104 and 455.436 for exclusion verification and 26 CFR 301.6109-1 for the purpose of reporting tax information. DHS may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the name and Social Security Number (SSN) provided below.

Do not leave any area of this section blank, failure to fully complete will result in the denial of your application. Put "N/A" for any area that is not applicable.

Street address: ________________________ City: ___________________ State: ________

ZIP code *(+4)*: _________________________ County: ______________________________

Mailing address *(if different from above)*: ______________________________________

City: __________________________ State: _______ ZIP code *(+4)*: ___________________

County: _____________________________________

Phone number: __________________ Email: ___________________________________

Date of birth: _________________________________ SSN: ___________________________

Have you been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid or the Title XXI Services Program since the inception of those programs? ☐ Yes ☐ No

Have you been terminated or excluded from participation as a provider in Medicare or any state Medicaid or Children's Health Insurance Program (CHIP) program? ☐ Yes ☐ No

☐ I do not have an existing Medicare, Medicaid, CHIP or Oregon DHS Provider Number

☐ I have an existing Medicare, Medicaid, CHIP or Oregon DHS Provider Number (list below):

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Submitting Agency Information (optional)

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Submitting Brokerage/CDDP/CIIS

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Submitting Brokerage/CDDP/CIIS contact email

5. **Eligibility and continued participation:** Eligibility and continued participation as a PSW is conditioned on Provider's execution and delivery of this Agreement, any required certifications or trainings and the continued accuracy of that information. Provider must continue to meet all the eligibility requirements as stated in OAR 411-375-0020, subject to verification by DHS.

6. **Provider suspensions and payment recovery:** Failure to comply with the terms of this Agreement, ODDS rules, DHS and OHA rules, or failure of the application to be accurate in any respect, may result in inactivation of the Medicaid provider number, termination of this Agreement, and/or payment recovery pursuant to OAR chapter 411, division 375 and OAR chapter 407, division 120 rules.

7. **Statewide Registry and Referral System:** The Oregon Home Care Commission has an internet-based, statewide Registry and Referral System (RRS) to assist Recipients in finding qualified in-home providers. Provider understands that if Provider agrees to be referred to prospective client-employers *(Recipients)* through the RRS, Provider's contact information *(name, phone number, and provider number)* will be released to anyone seeking in-home services, and that if Provider does not want Provider's contact information disclosed, Provider will not be eligible for referral to prospective Recipients.

8. Provider signature

I have read the forgoing Provider Enrollment Application and Agreement and the attached Exhibit A and any endorsement addendums, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for other sanctions as provided by statute, administrative rule, or this Agreement.

Print name of provider: ______________________________

______________________________ ______________________________

Signature of provider Signature/Effective date

Return completed document to:

Department of Human Services
ODDS Contracts and Provider Administration Unit
500 Summer St., NE E-09
Salem, OR 97301

OR

Email: psw.enrollment@state.or.us

OR

Fax: 503-947-5044

NOTE: This form may contain your personal information. If you return the form by unsecured email, there is some risk it could be intercepted by someone you did not send it to.

If you are not sure how to send a secure email, consider using regular mail or fax.