PSW Renewal

*ID Required. Return in-person

☐ Demo	Received:	
☐ PEAA	Received:	
☐ CHC	Received:	

Process may take up to 12 weeks
(unless additional information is needed)

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PSW
(PERSONAL SUPPORT WORKER)
DEMOGRAPHIC FORM

***REQUIRED**

* CHECK ALL THAT APPLY:	☐ NEW APPLICANT ☐ ADD CLIENT ☐ NO CLIENT	☐ UPDATE DEMOGRAPHICS/INFORMATION ☐ CRIMINAL HISTORY CHECK RENEWAL
PREFERRED LANGUAGE:	ENGLISH ____ SPANISH ____ OTHER: _____	
* PSW eXPRS SPD PROVIDER NUMBER (Current PSW Only):		
* LAST NAME:	* FIRST NAME:	
* MAILING ADDRESS: (Street, City, State, & Zip Code)		
* EMAIL ADDRESS:		
* PHONE NUMBER:		
* DATE OF BIRTH:	* SOCIAL SECURITY NUMBER:	
* CLIENT/INDIVIDUAL NAME:	* CLIENT DOB AND AGE:	
* RELATIONSHIP TO CLIENT/INDIVIDUAL:	☐ PARENT ☐ NOT RELATED	
* ARE YOU CURRENTLY AN AGENCY PROVIDER? ☐ No ☐ Yes IF SO, WHAT AGENCY: _____	* ARE YOU A STATE OF OREGON EMPLOYEE? ☐ No ☐ Yes IF SO, WHAT DEPARTMENT: _____	
* EMPLOYER NAME:		

DATE STAMP:

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Marion County
OREGON
Health & Human Services

Background Check Information Form

Please bring this completed form and current ID/DL with you to our front desk

Last Name: _____ First Name: _____

Middle Name: _____ Sufix: (circle one) Sr, Jr, III, IV, V

Gender: ☐ Male ☐ Female ☐ Other _____

Social Security # _____ - _____ - _____ Date of Birth: _____/_____/_____
(Please note this is voluntary, but required for portability)

Email:

Permanent/Physical (Address) _____

City: _____ State: _____ Zip Code: _____ County: _____

Check if mailing address is
☐ Same as permanent/physical address

Mailing address (only if different from permanent/physical) _____
_____

Phone # _____ - _____ - _____ Type: (circle one) Home – Mobile – Office – Message

Prior Names and Aliases / Prior out of State Addresses

☐ The subject individual reports s/he has no other names or aliases. ***(If applicable see back side)***

☐ The subject individual reports that s/he has not lived out of State during the past 5 years for more than 60 days ***(If applicable see back side)***

Verify Identity:

ID/DL Number: _____ Exp Date: _____/_____/_____ Issuing State/Authority: _____

☐ **I authorize Marion County to initiate this background check request.**

Signature: _____ Date: _____

Please complete the Authorization and Disclosure that will be E-MAILED to you from bcu.orchards@odhsoha.oregon.gov. Once the form has been entered and completed the background check will begin. If not completed and returned within 7 days the background check will close and you will need to restart the process.

(Only if applicable)

Prior Name and Aliases

Prior Names and Aliases, including maiden names, married names, name changes, and any name the subject individual has used or been known by. Required for the background check to be complete and accurate.

Name: _____ Last name: _____ Middle name: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____/_____/_____

Name: _____ Last name: _____ Middle name: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____/_____/_____

Previous Addresses

Enter all addresses you have lived out of the state during the specified time frame.

City: _____ State: _____ Zip code: _____ Year from: _____ Year to: _____

City: _____ State: _____ Zip code: _____ Year from: _____ Year to: _____

City: _____ State: _____ Zip code: _____ Year from: _____ Year to: _____

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**)*:

☐ 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):

_____

Submitting Agency Information (optional)

Marion County Intellectual and Developmental Disabilities

Submitting Brokerage/CDDP/CIIS

ddprocessing@co.marion.or.us

Submitting Brokerage/CDDP/CIIS contact email

AGREEMENT:

This Agreement sets forth the relationship between the State of Oregon, Department of Human Services (DHS), Office of Developmental Disabilities, Oregon Health Authority (OHA), and the Provider regarding payment by DHS or entities funded and authorized by DHS to pay for prior-authorized publicly funded in-home services provided to an eligible Recipient.

Please review this Agreement carefully before signing. It outlines your obligations as a Medicaid Provider in the State of Oregon. Failure to follow this Agreement may result in the termination of your Provider number.

1. **Compliance with applicable laws**:

   Provider understands and agrees:

   a. Provider shall comply with federal, state and local laws and regulations applicable to items and services under this Agreement, including but not limited to Oregon Administrative Rules (OAR) 407-120-0325.

   b. That if any term or provision of this Agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Agreement did not contain the term or provision held to be invalid.

   c. That failure to comply with the terms of this Agreement or any applicable DHS rules may result in termination, inactivation, or payment recovery, subject to provider appeal rights, pursuant to OAR 411-375-0070 and 411-375-0080.

   d. Provider is a Mandatory Reporter per ORS 419B.005 to 419B.050 and ORS 124.050 to 124.095.

   e. If Provider provides transportation services, Provider shall comply with all applicable licensing, certification and regulatory requirements as set forth by Federal and State statutes, regulations and insurance requirements identified in OARs necessary to provide Community and Employment-Related Transportation Services as a condition for receipt of payment for such services.

2. **Recipient eligibility:** Provider will be paid pursuant to this Agreement, the Collective Bargaining Agreement between the Oregon Home Care Commission (OHCC) and Services Employees International Union (SEIU), Local 503, and applicable administrative rules in effect on the date of service for services to a Recipient who has an eligible service plan that has been approved by DHS or an entity authorized to approve services through a contract with DHS. Any payment made for services provided outside of the service plan or payment for services in excess of the approved service plan or payment for services to ineligible Recipients are considered overpayments and are the sole responsibility of the Provider and shall be repaid to DHS if such payments have been made by DHS.

3. **Recordkeeping; access; confidentiality of Recipient's records:**

Provider understands and agrees that:

a. Recordkeeping:

i. Provider shall maintain such records (e.g. timesheets, incident reports (IR's), and progress notes) as are necessary to fully disclose the specific care and services provided to an eligible Recipient served under this Agreement for which reimbursement is claimed, in compliance with applicable administrative rules.

ii. Provider is responsible for the completion and accuracy of financial and clinical records and all other documentation regarding the specific care and services for which payment has been requested.

iii. Provider shall retain and keep accessible all records described above in 3(a)(i) for the longer of: six years following final payment and termination of this Agreement; any period as required by applicable law, including retention schedules set forth in OAR chapter 166, division 150; or until the conclusion of any audit, controversy, or litigation arising out of or related to this Agreement.

b. Access: All financial and timekeeping records and all other documentation pertaining to services rendered under this Agreement shall be made available to DHS, OHA, the Recipient's case managing Community Developmental Disability Program (CDDP), Recipient's brokerage, Children's Intensive In-Home Services (CIIS), Oregon Department of Justice Medicaid Fraud Unit, the Oregon Secretary of State's Office and the federal government, and their duly authorized representatives to examine, audit and make copies upon demand.

c. Confidentiality: A Recipient's records are confidential and may be given only to the Recipient, or to others with the prior written consent of the Recipient, the Recipient's legal guardian, or other person acting with power of attorney for the Recipient and in compliance with all applicable state and federal law requirements, or the entities named in the above Access section, or for purposes directly connected with the administration of the public assistance laws and this Agreement.

4. **Active enrollment**: By signing this Agreement, the Provider agrees Provider is available and able to provide services to one or more Recipients who are eligible for publicly-funded in-home services in Oregon. This Agreement may be inactivated if services are not authorized or paid during a twelve-month period. Following inactivation, the Provider may reapply for enrollment as a PSW if Provider wants to provide services to DHS Recipients.

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

DHS | Oregon Department of Human Services
INTELLECTUAL/DEVELOPMENTAL DISABILITIES

Personal Support Worker
Provider Enrollment Application and Agreement
Exhibit A

1. MEDICAID PARTICIPATION

Provider understands and agrees that:

A. Information disclosed by Provider is subject to verification. This information will be used for purposes related to the administration of the Medicaid program;

B. Provider will notify DHS of any changes which would affect this Agreement, or payment for services covered by this Agreement, within thirty (30) days of the change;

C. Provider shall, upon reasonable request by DHS, OHA, Oregon Medicaid Fraud Unit, Oregon Secretary of State's Office, Center for Medicare and Medicaid Services or their agents or designated contractors, grant immediate access to review and copy all records relied on by Provider in support of care and services provided under this Agreement. The term "immediate access' means access to records at the time the written request is presented to the Provider;

D. Provider is not in violation of any Oregon Tax Laws. For purposes of this certification, "Oregon Tax Laws" means a state tax imposed by Oregon Revised Statutes (ORS) 320.005 to 320.150 and 403.200 to 403.250 and ORS chapters 118, 314, 316, 317, 318, 321, and 323 and the Elderly Rental Assistance (ERA) program under ORS 310.630 and 310.706 and local taxes administered by the Department of Revenue under ORS 305.620.

E. Provider is not subject to backup withholding because Provider is exempt from backup withholding, has not been notified by the IRS that Provider is subject to backup withholding because of failure to report all interest or dividends, or the IRS has notified Provider that it is no longer subject to backup withholding.

F. Provider has not and will not discriminate against minority, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts.

G. Provider is not included on the list titled "Specially Designated Nationals and Blocked Persons" maintained by the Office of Foreign Assets Control of the United States Department of Treasury and currently found at: https://www.treasury.gov/ofac/downloads/sdnlist.pdf;

H. Provider shall at all times, meet required trainings and applicable qualifications, professionally competent to perform work under this Agreement. Failure to complete

trainings or meet the applicable qualifications may result in the inactivation of a provider's enrollment to perform a service.

I. Any communication or notices from the Provider shall be given in writing via personal delivery, via e-mail, facsimile, or regular mail, postage prepaid, to DHS. Any communication or notice so addressed and mailed by regular mail shall be deemed received and effective five days after the date of mailing; if transmitted by facsimile, it shall be deemed received and effective on the day the transmitting machine generates a receipt of successful transmission if during normal business hours or the next day if after normal business hours; if delivered by e-mail, it shall be deemed received and effective on the day and time noted in the receiving email system; and if delivered by personal delivery, it shall be deemed received and effective when actually delivered and confirmed by telephone to DHS.

J. All information submitted by Provider in this Agreement is true and accurate. Any deliberate omission, misrepresentation or falsification of any information provided or contained in any communication supplying information to DHS may be punished by administrative or criminal law or both, including, but not limited to, refusal to issue a DHS provider number, revocation of the DHS provider number and recovery of any overpayments.

K. Provider acknowledges that the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" *(as defined by ORS 180.750)* that is made by *(or caused by)* the Contractor and that pertains to this Agreement or to the services for which the work pursuant to this Agreement is being performed. Provider certifies that no claim described in the previous sentence is or will be a "false claim" *(as defined by ORS 180.750)* or an act prohibited by ORS 180.755. Provider further acknowledges that in addition to the remedies under this Agreement, if it makes *(or causes to be made)* a false claim or performs *(or causes to be performed)* an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against Provider.

2. SERVICES

Provider understands and agrees that:

A. Provider shall perform services identified in the Recipient's service plan in accordance with the following rules as applicable:

1. OAR chapter 411, division 305 *(Family Support Services)*
2. OAR 411-034-0000 through 411-034-0090 or subsequent rules *(State Plan Personal Care)*
3. OAR chapter 411, division 375 *(Independent Providers Delivering Developmental Disability Services)*
4. OAR chapter 411, division 450 *(Community Living Supports)*
5. OAR chapter 411-435-0050(6) *(Community Transportation)*
6. OAR chapter 411, division 345 *(Employment Services)*

B. Provider shall not enter into any subcontract or authorize another person to perform the services authorized by this Agreement.

3. PAYMENT

Provider understands and agrees that:

A. DHS or a Fiscal Management Administration Servicer (FMAS), on behalf of DHS, shall pay Provider for work provided under this Agreement that is authorized for payment and applicable to PSW services. Payments made by DHS from public funds are subject to ORS 293.462. DHS and Provider's obligations with respect to DHS payments to Provider are set forth in OAR chapter 411, divisions 027 and 370; OAR chapter 407, division 120; OAR chapter 410, division 120; and OAR chapter 411, division 375 rules.

B. Payment received from DHS or a FMAS on behalf of DHS for any service provided under this Agreement is payment in full. Provider shall not make any additional charge to eligible Recipients, or their representative, served under this Agreement except as may be specifically allowed by DHS rules. Payment amount and methodology for making a payment is determined using the procedures described in applicable DHS rules. By accepting payment, Provider certifies compliance with all applicable DHS rules. Provider shall not receive payment for work performed after the expiration or termination of this Agreement.

C. As a condition of payment, Provider must meet and maintain compliance with this Agreement and payment rules OAR 407-120-0300 through 407-120-1505, OAR chapter 410, division 120, 42 CFR 455.400 through 455.470, as applicable, and 42 CFR 455.100 through 455.106.

D. Any overpayment made to Provider by DHS or a FMAS may be recouped as authorized by law and in accordance with the applicable Collective Bargaining Agreement including, but not limited to withholding of future payments to Provider.

E. Payment for PSW services performed is contingent on DHS receiving from the Oregon Legislative Assembly appropriations, limitations, allotments or other expenditure authority sufficient to allow DHS, in its reasonable administrative discretion, to continue to make payments.

F. Provider is not an officer, employee, or agent of the State of Oregon or DHS and shall not be deemed for any purpose *(other than collective bargaining as provided by State law)* to be an employee of the State of Oregon. The Provider shall perform all work as an employee of an eligible Recipient or the Recipient's representative (*employer)* who is responsible for determining the appropriate means and manner of Provider's performance. The Provider further understands and agrees that Provider is not employed by any CDDP, Brokerage or other DHS contractor and shall not for any purposes be deemed to be an employee of the CDDP, the Brokerage or other DHS contractor regardless of whether one of these entities assists the employer in selecting the Provider or assists in managing the payroll. The employer is responsible

for interviewing and hiring his or her own employees, including Provider. The terms of Provider's employment relationship are the responsibility of the employer.

G. Prior to providing any services to a Recipient, Provider must have established an employment relationship with the Recipient or the Recipient's Representative (*employer)* and both Provider and Provider's employer must be enrolled with the FMAS to be eligible for payment under this Agreement.

H. Provider enrollment and issuance of a Provider number does not constitute a guarantee of work or any minimum amount of work.

4. Duration and termination of Agreement

A. Except for the PSW Job Coach Specialty, this Agreement shall expire on the last day of the month 5 years from the effective date of this Agreement. The PSW Job Coach Specialty shall expire on the last day of the month 2 years from the effective date of this Agreement. If the Provider has met all applicable requirements, the effective date of this Agreement is the date it is signed by the provider.

B. DHS will terminate or inactivate this Agreement if:

1. DHS issues a final order revoking the Provider number based on a finding under termination terms and conditions established in OAR 411-375-0070;
2. The Provider fails to submit timely, complete, and accurate information or cooperate with any screening requirements, unless DHS determines it is not in the best interest of the Medicaid program;
3. The Provider is terminated under Title XIX of the Social Security Act or under a Medicaid program or CHIP program of any State;
4. The Provider fails to submit fingerprints in a form and manner to be determined by DHS within 30 days of a Centers for Medicare & Medicaid Services (CMS) or a DHS request, unless DHS determines it is not in the best interest of the Medicaid program;
5. CMS or DHS determines that the Provider has falsified any information provided on the application or if CMS or DHS cannot verify the identity of the Provider applicant;
6. DHS fails to receive funding, appropriations, limitations, or other expenditure authority at levels that DHS or the specific program determines to be sufficient to pay for the services or items covered under this Agreement;
7. Federal or state laws, regulations, or guidelines are modified or interpreted by DHS in a manner such that either providing the services or items under the Agreement is prohibited, or DHS is prohibited from paying for such services or items from the planned funding source;
8. The Provider no longer qualifies as a Provider. The termination will be effective on the date Provider is no longer qualified; or,
9. The Provider fails to meet one or more of the requirements governing participation as a DHS enrolled provider including the requirement to pass a

background check every two years. In addition to termination or inactivation of the Agreement, the Provider number may be immediately suspended, in accordance with OAR 407-120-0360. No services or items shall be provided to recipients during a period of suspension. And,

10. DHS may terminate this Agreement at any time with written notification to Provider.

C. Provider may terminate this Agreement at any time, subject to specific provider termination requirements in OHA rules, DHS program-specific rules, federal regulations by submitting a written notice in person or by e-mail listing a specific termination effective date. Termination of this Agreement does not relieve the Provider of any obligations for covered services or items provided for dates of service during which the Agreement was in effect. Provider notifications must be submitted a minimum of 60 days prior to the termination effective date and must be sent to the local office and to the ODDS Contracts and Provider Administration Unit at the address below. The Provider and DHS may mutually agree in writing to an immediate termination date or any later date agreed to in writing.

5. Indemnification

PROVIDER SHALL INDEMNIFY AND DEFEND THE STATE OF OREGON, CDDPS, BROKERAGES OR THEIR FISCAL INTERMEDIARIES, THEIR RESPECTIVE AGENCIES AND THEIR OFFICERS, EMPLOYEES AND AGENTS FROM AND AGAINST ALL CLAIMS, SUITS, ACTIONS, LOSSES, DAMAGES, LIABILITIES, COSTS AND EXPENSES OF ANY NATURE WHATSOEVER ARISING OUT OF, OR RELATING TO THE ACTS OR OMISSIONS OF PROVIDER UNDER THIS AGREEMENT.

Return completed document to:

DD Processing
Marion County Health & Human Services
3180 Center St NE, Suite 2100
Salem, OR 97301
503-576-4593

Email: ddprocessing@co.marion.or.us

Fax: 503-576-4593

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.

Marion County CDDP PSW Renewal Process
Existing PSW - **RENEWAL**

STEP 1 - FORMS

If Credentials are expired DO NOT WORK

- **FORMS REQUIRED:** Employee Demographic Form & Background Form (CHC)
- Complete and **submit** forms in person to: 3180 Center St NE, Salem, OR 97301
  - * ***ID must be presented, verified, and copied at this time.*** *(Front desk, 2nd fl)*

STEP 2 - BCU

- **CHC:** A seperate email will be sent from noreply@innovativearchitects or bcu.orchards@odhsoha.oregon.gov that must be completed to authorize the background check. (
  - * DENIED: PSW will not move forward in the process.
  - * APPROVED: PSW will move forward
- **FINGERPRINTS** (If requested): Requests are prompted for various reasons including living outside of Oregon within last 5 years and/or criminal history. DD Processing will send an email, if fingerprints are needed.

STEP 3 - EXPRS

EXPIRED Credentials

- **Expired background** check will result in credential lapse. PSW will NOT be authorized to work until cleared background check has been reflected in eXPRS..
  - * An email will be sent to you from DD Processing with successful renewal, and your authorizations will be extended appropriately
- **Expired PEAA** will result in credential lapse. PSW will NOT be authorized to work until eXPRS has been updated.

If PSW has been innactive (not working) for more than 18 months please submit New Enrollment Packet and follow (NEP) Flow Chart

STEP 4 - BEGIN WORK

- You may begin to work once Step 1-3 have been completed and you have received an email from DD Processing confirming that you are "Good to Go" and ready to work.

Approximate Time Line: 4-6 weeks	STEP 1	STEP 2	STEP 3	
	48 - 72 hours	2 - 4 weeks	Arrange with DD Processing	Steps 1 - 4 are completed and verified
	DO NOT WORK			OK TO WORK