Personal Support Worker

Application Packet

Please fill out the forms in this packet and return to the designated places listed on the setup checklist.

VERY IMPORTANT NOTICE!!!

It is crucial to understand that this position requires regular use of a computer, internet, and email. You will also need access to a printer.

Creative Supports, Inc. is not your employer; your employer is determined by the individual receiving support services, or their legal representative.

Updated 4/12/2023

This is a Personal Support Worker (PSW) Application Packet.

This packet includes required forms and applications that are necessary to start the enrollment process for becoming a PSW and getting you connected to the individual receiving support services.

Please read through the *PSW Information Packet* before proceeding.

It is important that you understand what it means to be a PSW and the necessary job requirements before applying.

The forms in this packet *must* be completed and submitted correctly.

You cannot start working as a PSW until your enrollment is completed and you have a signed Service Agreement from the individual's Personal Agent.

Creative Supports, Inc. (CSI) is a non-profit brokerage, contracted through Oregon Developmental Disability Services in part to process timesheets and mileage logs that allow the disbursement of designated state and federal funds under the directions of the individual receiving services, their legal guardian, and Oregon Administrative Rule.

If you have any questions regarding the materials in this packet, you may contact the eXPRS Unit at CSI at 541-864-1673.

Setup Checklist for New Personal Support Worker

The process to become a PSW can be quite complex. This checklist is helpful in tracking your enrollment as a PSW.

GENERAL JOB REQUIREMENTS

- Must have a personal email address. It cannot be an email from a friend/family.
- This position includes frequent use of a computer, the internet, and a printer.
- It is recommended that you access the eXPRS help guides for reference in utilizing the State's billing system (https://apps.state.or.us/exprsWeb/login.do → eXPRS documentation)

CHECKLIST	CSI = Creative Supports Inc.
☐ Contact Information Form	* Complete and return to CSI
☐ Qualified Provider Agreement	* Complete and return to CSI
☐ Mandatory Abuse Reporting Notice	* Complete and return to CSI
☐ Consent to Retain Copies of Confidential Documents	* Complete and return to CSI
☐ Copy of ODL and Auto Insurance	* Submit to CSI if providing transportation
☐ PPL (FI) PSW Request Form	* Complete and return to CSI
☐ Criminal Background Check Application	* Complete and return to CSI with photo ID
☐ Criminal Background Check Approval Letter	* Mailed by QED staff from CSI office once Criminal History Check (CHC) is approved.
☐ PSW Provider Enrollment Application & Agreement (PEAA)	* Submit to PSW Enrollment Unit
☐ SPD Provider Number (Applied for with PEAA)	* Emailed from PSW Enrollment Unit
☐ User Enrollment Form (UEF) Enroll Individual Provider	* Complete and submit to eXPRS, after SPD number is provided.
☐ Username/Password (Applied for with UEF)	* Emailed from eXPRS, gives you access to your eXPRS account for billing.
☐ Verify Approved to Work Status in eXPRS by logging in.	* SPD#, current CHC, current PEAA.
☐ PPL (FI) Enrollment Paperwork	* Issued by mail/email, **returned to PPL** via fax/email to establish Employment Relationship
☐ Identify Employer and notify the Personal Agent (PA)	* EXPRS Specialist verifies Approved to Work Status and established Employment Relationship in eXPRS then notifies PA.
☐ Signed Service Agreement, made by CSI Personal Agent	* Return to CSI and Retain Copy
☐ New PSW Orientation – Oregon Home Care Commission	* Must attend before employment begins. (SPD number will not be assigned until Orientation is complete.)

Contact Information

PERSONAL SUPPORT WORKER CONTACT INFORMATION FORM

Name:		Birthdate:	
Home Phone:		Cell:	
Physical Address:			
City:	State:	ZIP Code:	County:
Mailing Address:			
City:	State:	ZIP Code:	County:
Email:			

SIGNATURE VERIFICATION

I authorize the verification of the information provided on this form is accurate.

Signature of Employee / PSW:	Date:

Qualified Personal Support Worker Agreement

Creative Supports, Inc.

*** Sign and return to Creative Supports, Inc. office.***

Before you can start working, you must:

1. Complete and pass the Criminal History Records Check. Prior to working, confirmation must be received by our office that you are authorized to work. This process can take between 4-10 weeks.
2. Complete the Provider Enrollment Application and Agreement form, submit to the DHS office, and be issued an SPD Provider ID number.
3. Attend New Worker Orientation offered online athttps://www.carewellseiu503.org.
4. Be qualified to work in the United States *(See IRS Form I-9)*
5. Be a Mandatory Abuse Reporter.
6. Present copies of any license or certificates that you are required to have for this job (documents required by the State of Oregon or the County Developmental Disability Office).
7. If driving is a part of your job, you need to submit copies of your valid Oregon Driver's License and **current** proof of auto insurance.
8. Complete employment enrollment through Public Partnerships, LLC. and have a good-to-go employment relationship.
9. Sign a Service Agreement created by the individual's Personal Agent.

Oregon Administrative Rules (OAR) state that Seniors and People with Disabilities (SPD) dollars **cannot pay for any work** done by employees until they have complied with all of the above steps.

Because you are paid with public funds, these rules must be followed. Support Service funds will not be used to pay for services provided by an unqualified employee.

I,_____(print name) agree that I will not work for an individual receiving support services through Creative Supports, Inc. without passing a Criminal History Check, being issued an ODDS SPD Provider ID number, showing proof of my ability to work in the United States, and a signed Service Agreement. I will act as a mandatory abuse reporter, understanding my role in supporting this protected population by reporting all suspected abuse and neglect. I will respect the confidentiality of the individual and my employer.

If I work before clearing a criminal history check and being qualified, I understand that I will not be paid through support service funds.

Print Name:_____ **Date:**_____

Signature:_____

Oregon Department of Human Services

Mandatory Abuse Reporting Notice: Adults with Developmental Disabilities

To report abuse call 1-855-503 SAFE (7233)

As an individual providing services to adults with developmental disabilities, you are a **Mandatory Reporter** according to Oregon law (ORS 430.765). According to the law, if you have reasonable cause to believe an adult with developmental disabilities has been abused, or that any person with whom you come in contact has abused such an adult, you must **immediately** report the abuse to the community developmental disability program, the Oregon Department of Human Services (ODHS), or to a local law enforcement agency. Law enforcement must be called if there is reason to believe a crime has been committed. When applicable, you should also follow your agency policies and procedures so that immediate steps are taken to protect the victim of the abuse.

Abuse of an adult with developmental disabilities means:

1. Abandonment:

   Abandonment, including desertion or willful forsaking of an adult or the withdrawal or neglect of duties and obligations owed a person with a developmental disability by a caregiver or other person.

2. Physical abuse:

   - Any physical injury to an adult caused by other than accidental means, or that appears to be at variance with the explanation given of the injury.
   - Willful infliction of physical pain or injury upon an adult.

100-446050_DHS 4624A (04/2024)

3. Sexual abuse:

- Sexual contact with a nonconsenting adult or with an adult considered incapable of consenting to a sexual act under ORS163.315.
- Sexual harassment, sexual exploitation or inappropriate exposure to sexually explicit material or language.
- Any sexual contact between an employee of a facility or paid caregiver and an adult served by the facility or caregiver.
- Any sexual contact between an adult and a relative of the adult other than a spouse.
- Any sexual contact that is achieved through force, trickery,threat or coercion.
- Sexual Abuse (Criminal) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427,163.465 or 163.467.

"Sexual abuse" does not mean consensual sexual contact between an adult and a paid caregiver who is the spouse of the adult.

"Sexual contact" has the meaning given that term in ORS163.305.

4. Neglect:

- Failure to provide the care, supervision or services necessary to maintain the physical and mental health of an adult that may result in physical harm or significant emotional harm to the adult.
- The failure of a caregiver to make a reasonable effort to protect an adult from abuse.
- Withholding of services necessary to maintain the health and well-being of an adult that leads to physical harm of an adult.

5. Verbal abuse:

   To threaten significant physical or emotional harm to an adult using: Derogatory or inappropriate names, insults, verbal assaults, profanity or ridicule. Harassment, coercion, threats, intimidation, humiliation, mental cruelty or inappropriate sexual comments.

6. Financial exploitation:

   - Wrongfully taking the assets, funds or property belonging to or intended for the use of an adult.
   - Alarming an adult by conveying a threat to wrongfully take or appropriate money or property of the adult if the adult would reasonably believe that the threat conveyed would be carried out.
   - Misappropriating, misusing or transferring without authorization any money from any account held jointly or singly by an adult.
   - Failing to use the income or assets of an adult effectively for the support and maintenance of the adult.

7. Involuntary seclusion:

   Involuntary seclusion of an adult for the convenience of the caregiver or to discipline the adult.

8. Wrongful Restraint:

   A wrongful use of a physical or chemical restraint upon an adult, excluding an act of restraint prescribed by a physician licensed under ORS chapter 677, physician assistant licensed under ORS 677.505 to 677.525, naturopathic physician licensed under ORS chapter 685 or nurse practitioner licensed under ORS 678.375 to 678.390 and any treatment activities that are consistent with an approved treatment plan or in connection with a court order.

9. Death:

   Any death of an adult caused by other than accidental or natural means.

10. Public Education Programs through 12th grade:

- The restraint or seclusion of an adult with a developmental disability in violation of ORS 339.288, 339.291 or 339.308.
- The infliction of corporal punishment on an adult with a developmental disability in violation of ORS 339.250 (9).

These abuse definitions can be found in ORS 430.735.

In accordance with law, your identity as the person making the report is confidential. Further, the law protects you from retaliation from a community facility, community program or individual when you make a report in good faith. You may not be discharged or transferred from one location of an agency to another, terminated from your job, demoted or have your pay lowered, or denied contact with the facility or its residents because you made a good faith report of suspected abuse. If you feel you have been retaliated against, you have the right to seek private legal action. Any agency, program or individual who retaliates against someone because of a good faith report of suspected abuse may be liable to that person for actual damages.

By signing this form, you are acknowledging that you understand the Oregon's mandatory abuse reporting requirements concerning adults with developmentally disabilities. If you do not understand the mandatory requirements, ask to have them explained to you before signing this form.

I received and read this notice about my mandatory abuse reporting obligations.

Please sign your name Today's Date

Please print or type your name Today's Date

PLEASE RETURN THIS FORM TO YOUR PROGRAM

Mandatory Reporting Notice – Adults, IDD Updated Jan 2024

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the ODHS |OHA Office of Training, Investigations and Safety by email to OTIS.Communications@odhsoha.oregon.gov, by phone (503) 945-9495 or toll free at 1-866-406-4287 (voice). We accept all relay calls.

Adults with Intellectual/Developmental Disabilities (I/DD)

- Quick Abuse Reporting Reference Card -

Instructions:

- Enter your local Community Developmental Disabilities Program or local law enforcement agency phone number using the fillable form
- Print on standard 8.5 x 11 paper
- Cut the rectangle below with the information and discard this section
- Fold the rectangle by the vertical line to a business card size and keep for your reference
- The card has a web link to the Abuse Reporting Notices providing the abuse definitions

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Intellectual/Developmental Disabilities	Abuse Types
Report Abuse **1-855-503 SAFE (7233)** **Emergencies 911** **Report Crime to Police** _____	•Abandonment •Death •Financial Exploitation •Involuntary Seclusion •Neglect •Physical •Sexual •Wrongful Restraint •Verbal **Go to Resources/Notices** **https://go.usa.gov/xzCxr**

Consent to Retain Copies of Confidential Documents

Creative Supports, Inc.

I, _____ (print name) authorize Creative Supports, Inc. (CSI) to maintain confidential information such as, but not limited to, a copy of my driver's license and proof of auto insurance. I understand that this information will be used as a part of the evidence of my qualifications to provide Medicaid funded services to individuals who may choose to employ me as their Personal Support Worker.

I further agree to provide updates to all of my information at this office, to assure that my qualifications are maintained accurately and current as required by Medicaid. I understand that updating my information at the CSI office does not mean that my information will be updated with all state entities.

Signature: _____

Date: _____

PERSONAL SUPPORT WORKER

Public Partnerships, LLC. Request Form

REQUIRED IF BEING HIRED BY CUSTOMER AND COMMON LAW EMPLOYER			
Please fill out and return to CSI			
Employee Information			
Name:		SPD Number:	
Date of birth:	SSN:	Phone:	
Physical Address:			
City:	State:	ZIP Code:	County:
Mailing Address:			
City:	State:	ZIP Code:	County:
Email:			
PROPOSED CUSTOMER / EMPLOYER INFORMATION *(if known)*			
Customer Name *(May be different than Employer)*:			
Employer Name:			
SIGNATURE VERIFICATION			
I authorize the verification of the information provided on this form is accurate.			
Signature of Employee / PSW:		Date:	

Request for Criminal History Background Check

In order to be employed by a client that receives case management services from Creative Supports Inc., you must have a current and valid Criminal History Check (CHC). All people who work with clients that receive case management services through Creative Supports are required to complete a CHC **every 2 years**. Without a current CHC, you cannot provide paid supports to Creative Support clients. It takes approximately 8 weeks to process your Criminal History Check and to assure that you have current credentials in the state payroll system known as eXPRS.

The following information is needed for Creative Supports to start the CHC process:

Name: _____
(as listed on your government issued ID)

Social Security # (Note This is voluntary): _____

Date of birth (mm/dd/yyyy): _____

Residential address: _____

Mailing address (if different): _____

Prior names and aliases: _____

Gender: _____

Phone: _____Type of Phone (home, mobile, etc.): _____

2nd Phone: _____Type of Phone (home, mobile, etc.): _____

Email (required): _____

Residential History outside Oregon, past five years: _____

Employee Type: PSW

Position requires direct contact with: ☐Adults ☐confidential information
☐Finances/Financial records ☐Information Technology Systems ☐seniors

Position requires: ☐Driving

You will receive an email at the address you list above with instruction how to complete your CHC online. Please note if fingerprints are required to make a final fitness determination, you will receive further instructions.

A copy current government issued photo ID is required to be attached

DHS | Oregon Department of Human Services
INTELLECTUAL/DEVELOPMENTAL DISABILITIES

I/DD PERSONAL SUPPORT WORKERS ONLY

Clear form

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)

_____
Submitting Brokerage/CDDP/CIIS

_____
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:

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

OR

Email: PSW.Enrollment@odhsoha.oregon.gov

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.

Independent Provider User Enrollment Form

(PSW, Behavior Consultant, Employment/Discovery Providers)

INSTRUCTIONS

1. A red asterisk (*) indicates this information is required. Incomplete forms cannot be processed.

2. Send completed form by email to info.exprs@state.or.us or Fax to **503-947-5044**.

3. If the form is complete and your provider record is active, your form should be processed within a week, but may take longer; please be patient.

4. Once your eXPRS User Account has been created, you will receive two emails from info.exprs@state.or.us:

   - The 1st email contains generic information and includes several attachments.
   - The 2nd email will be secure email from DHS and includes your eXPRS Login Name and a temporary password.

   NOTE: Unless you already have one, you will have to set up an account with ODHS' secure email system. If you need assistance with a secure email, please contact the ODHS Service Desk at 503-945-5623 and choose option 3.

5. If you have not received an email within one week, please check your junk or spam folder. If it is not received within 10 days, please send an email to info.exprs@state.or.us to check on the status.

Maintain a copy of this form in your local file for audit purposes.
Send completed form to: info.exprs@dhsoha.state.or.us

eXPRS
Express Payment & Reporting System

Independent Provider
(PSW, Behavior Consultant, Employment/Discovery)
User Enrollment Form

* Indicates required fields. **Send completed form to: info.exprs@dhsoha.state.or.us or fax to 503-947-5044**

Additional form instructions are on the back.

***Indicate Action:** ☐ **Add User** ☐ **Change of Information** ☐ **Deactivate User**

***User's Name:** (Last, First, MI) *(Print Name)*

Already have an eXPRS Login?
☐ NO ☐ Yes, Login Name:

***Job Title** *(*check one)*:
- ☐ Personal Support Worker (PSW)
- ☐ Independent Behavior Consultant
- ☐ Independent Employment/Discovery Provider

***Provider Number**(s) *(SPD or eXPRS)*:

***User's Address:** *(Mailing Address)*

***City, State, Zip:**

***User's Phone Number:**

***User's Email:**

ADD	DEL	User Role/Description
☐	☐	**Provider PSW/IC/BC Claims Manager** – *able to Create/Submit/View Service Delivered (SD) billing entries via the eXPRS Desktop and/or eXPRS Mobile-EVV; able to Create/Submit/View PSW Travel Time claims; able to view Service Prior Authorizations (SPAs), provider credential information, claims and payment information; able to print timesheets.*

*I solemnly swear *(*check one)*:

☐ I acknowledge that **I also work** as an Agency Direct Support Professional (DSP).

☐ I acknowledge that **I do NOT work** as an Agency Direct Support Professional (DSP).

By signing, I acknowledge that failure to accurately represent my role as a Personal Support Worker or as an Agency Direct Support Professional (DSP) may be considered Medicaid fraud.

*Print User's Name:	
*User's Signature:	*Date: / /

Maintain a copy of this form in your local file for audit purposes.
Send completed form to: info.exprs@dhsoha.state.or.us