

New PSW Enrollment Packet

ID REQUIRED

***Keep PSW Enrollment Flow Chart and Resource List as references (last 4 pages).**

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PSW (PERSONAL SUPPORT WORKER)

DEMOGRAPHIC FORM

IN PERSON ID VERIFICATION REQUIRED

***REQUIRED**

* CHECK ALL THAT APPLY:	<input type="checkbox"/> NEW APPLICANT	<input type="checkbox"/> UPDATE DEMOGRAPHICS/INFORMATION
	<input type="checkbox"/> ADD CLIENT	<input type="checkbox"/> CRIMINAL HISTORY CHECK RENEWAL
	<input type="checkbox"/> NO CLIENT	
PREFERRED LANGUAGE:	ENGLISH ____ SPANISH ____ OTHER: _____	
* PSW eXPRS SPD PROVIDER NUMBER:		
* LAST NAME:	* FIRST NAME:	
* MAILING ADDRESS:		
* EMAIL ADDRESS:	* PHONE NUMBER:	
* DATE OF BIRTH:	* SOCIAL SECURITY NUMBER:	
* CLIENT/INDIVIDUAL NAME:	* CLIENT/INDIVIDUAL MEDICAID PRIME NUMBER:	
* RELATIONSHIP TO CLIENT/INDIVIDUAL:	<input type="checkbox"/>	
	<input type="checkbox"/> NOT RELATED	
* EMPLOYER NAME:		

DATE STAMP:



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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: _____ Suffix: (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 Mailing address (only if different from permanent/physical) _____
 Same as permanent/physical address _____

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 noreply@innovativearchitects, noreply-dev@innovativearchitects. Once the form has been entered and completed the background check will begin. If not completed and returned within 21 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: _____

Background Check Request

Instructions for Subject Individual (SI)

Read all of the instructions before completing the form.

As the subject of this background check, you are referred to in these instructions as the subject individual (SI). The qualified entity (QE) listed in box 1 is the agency where you are applying to work or hold a position. The qualified entity designee (QED) is a person at the QE who has received training from the Department of Human Services Background Check Unit (BCU) for background checks: the QED is usually your contact for doing this background check.

Section 2 – You, the SI, complete this section.

11. Type or print your complete name.
12. The disclosure of your Social Security number (SSN) is optional. The BCU requests the SSN solely for the purpose of positively identifying you during the background check process. If you do not provide a SSN, the BCU may request fingerprints to confirm identity.
13. Enter your date of birth (*mm/dd/yyyy*).
14. Enter your email address.
15. Check the box for your gender.
16. Enter your driver license or state ID, listing the state and the number.
17. Type or print all aliases or other names you have ever used.
18. Check this box only if you prefer to have correspondence from BCU sent to your mailing address rather than email. *BCU will send any correspondence via regular mail if it contains confidential information.*
19. Type or print your residence address. If you have a mailing address that is different from your residence, type or print it.
20. Type or print the phone numbers where you can be reached.
21. If you have lived outside of Oregon in the past five (5) years for more than 60 days in a row, check the “yes” box and provide details of your previous residences. If you have lived in Oregon for the entire past five (5) years, check the “no” box and go to #22.
22. Provide information on your criminal history. If you have never been arrested, charged, or convicted, check the “no” box and go to #23.

Disclose all criminal history — You must accurately and completely disclose all history (*adult and juvenile*) regardless of how long ago it happened. This includes all felonies, misdemeanors, probation violations and failures to appear. If you fail to list any part of your history, your application may be closed or you may be denied due to false statement. Any serious traffic offense such as reckless driving, driving under the influence of intoxicants (DUII) and driving while suspended (DWS), must be listed. Failure to appear, even for a minor traffic violation, must be listed.

If you are not sure if something should be listed, you should list it. For each charge, arrest, adjudication, or conviction, include the exact date (*mm/dd/yyyy*), location and the outcome. If you do not remember the exact date, round to the nearest month or year (*for example, if the date was sometime in May of 2013, use the date 01/01/2013; if the date was sometime in 2010, use the date 01/01/2010*).

You do not need to disclose any charge, arrest, conviction or adjudication which has been expunged or set aside. If you are uncertain (*for example, you do not have documented proof of court action, or you have not requested a copy of your record to confirm that the expunction or setting aside has occurred*), you may disclose without penalty: if you disclose anything which has been expunged or set aside, or provide documentation proving something has been expunged or set aside, BCU will in no way use any charge, arrest, conviction or adjudication which has been expunged or set aside in a weighing test or fitness determination.

If you have any new arrests, charges, convictions or adjudications after submitting this background check request form but before the final fitness determination:

Contact the agency where you are applying to work or hold a position. The QED will need to add this information, including any additional information you want to provide (see *instructions for #23 below*), to the background check request already submitted to BCU.

Violations and infractions: Minor moving and non-moving traffic violations are not required to be listed.

Note: Although you are not being asked in this form to disclose any history of your being considered an alleged or reported perpetrator of abuse, BCU will conduct an abuse check on you. If you would like to disclose any abuse history, you may do so by attaching additional pages to the background check request form, or giving them to your contact at the agency for which you are doing this background check.

23. **If you have criminal or abuse history, BCU will weigh several factors to decide if you are fit for the position for which you are applying. Respond to the following questions, attaching additional pages as needed. Attach documentation to support your responses.**

- What happened leading up to the criminal or abuse history?
- Explain the outcome of the criminal or abuse history.
- List any requirements resulting from each event.
- Describe any treatment, education and training specifically related to your history.
- How is your history relevant to your position?
- How has your life changed since your history?
- Explain how you no longer pose a risk to the physical, emotional or financial well-being of vulnerable people.
- List other information you believe would be helpful in making a decision in this case.

Note: Some convictions and conditions may be subject to ORS 443.004 or federal mandatory exclusions and a weighing test may not be allowed. See more information below under Possible Outcomes.

24. **CAREFULLY READ THE STATEMENTS IN THIS SECTION. YOUR SIGNATURE INDICATES YOUR UNDERSTANDING OF AND AGREEMENT WITH ALL STATEMENTS AND YOUR AUTHORIZATION TO RELEASE OF INFORMATION BY BCU.** Sign and date the form. Return it to the person listed in #2 or to your contact in the agency for which you are completing this background check request.

What is potentially disqualifying — Review the Department of Administrative Services (DAS) and the Provider background check rules available at <http://www.oregon.gov/DHS/BUSINESS-SERVICES/CHC/Pages/index.aspx> for a complete list of what is potentially disqualifying. If you have potentially disqualifying convictions or other potentially disqualifying criminal conditions, you may challenge your record if you believe it to be incomplete or inaccurate. See below regarding challenging. In general, the following are potentially disqualifying:

- All criminal convictions and adjudications.
- Other current or recent criminal actions, such as probation violations, sex offender registration, current diversion, conditional discharge, parole, or probation.
- Adult protective services history of physical or sexual abuse or financial exploitation assessed on or after Jan. 1, 2010 for which you were found to be responsible. Abuse information is provided to BCU by the Office of Abuse Prevention and Investigations and the Aging and People with Disabilities (APD) based on severity.
- Effective 12/01/2016, child protective services history held by the department, regardless of the type of abuse or the date of the initial report for which you were found to be responsible.

Possible outcome of your background check:

- **Approved:** Your background check is approved for the position listed on this form. An approval does not guarantee employment or placement.
- **Approved with restrictions:** Your background check is approved to work but are restricted to a specific client, a specific work site or a set of duties. This decision may be appealed. A restricted approval does not guarantee employment or placement.
- **Denial:** Based on the background check, you are denied. You may not hold the position listed on this form and you must be terminated immediately. This decision may be appealed, but you may not hold the position during the appeal.
- **Case closed:** If you do not provide a complete and accurate disclosure of your criminal history or you do not cooperate with this background check process, your application may be closed without a final decision. There are no appeal rights, but you may be able to reapply immediately.
- **Ineligible:** Oregon Revised Statute (ORS) 443.004 prohibits individuals from working in certain positions if they have one or more specific convictions. A complete list of convictions is available at <http://www.oregon.gov/DHS/BUSINESS-SERVICES/CHC/Pages/HB2442.aspx>. ORS 443.004 covers home care workers and personal support workers; adult foster homes; community-based care for seniors and individuals with disabilities (*excluding nursing facilities*), and all positions working with individuals with developmental disabilities. If found ineligible, you may not hold the position listed on this form and must be terminated immediately. You do not have appeal rights. The BCU will provide more information in the email or letter sent to you.

- **Mandatory exclusion:** If you have any convictions or conditions that would make you subject to a federal exclusion (*for example, the Service America Act, requirements for positions subject to the Centers for Medicare and Medicaid Services [CMS], etc.*), BCU will issue you a notice and you may not hold the position listed on this form and must be terminated immediately. You may have hearing rights if allowed under federal law. More details are available in the Provider rules at <http://www.oregon.gov/DHS/BUSINESS-SERVICES/CHC/Pages/index.aspx>.

Authority — BCU is authorized by state law to complete background checks on SIs who work, volunteer or live with individuals who are vulnerable to abuse or mistreatment (ORS 181A.195, 181A.200, 409.027 and 443.004; OAR 407-007-0200 to 407-007-0370, OAR 943-007-000 to 943-007-0501). Vulnerable individuals include children, senior citizens and individuals with physical disabilities, developmental disabilities or mental illness. A check may be required even if you, the SI, do not have direct contact with vulnerable individuals.

Sources checked — BCU may check information from the Driver and Motor Vehicle Services Division, Department of Corrections, Oregon State Police, Federal Bureau of Investigation and local, state and federal courts. BCU may use information from other criminal justice, corrections and law enforcement agencies and other state and local government agencies. You may be requested to provide fingerprints for a national criminal records check.

Challenging criminal information — You have the opportunity to challenge your criminal record if you believe it has inaccuracies. If you want to obtain a copy of your record, or challenge information in the record, you must contact the Oregon State Police, 503-378-3070, extension 330 (*for Oregon criminal records*) or the Federal Bureau of Investigation, 304-625-3878 (*for national criminal records*). You may request a copy of the national FBI report from BCU. Depending on your previous contacts with law enforcement and courts, you may need to contact several sources to find your complete criminal records. Contact information for law enforcement and courts is available online using search engines.

Rechecks — **This background check process may be repeated at any time while you work, reside or otherwise continue in this position.**

If you have questions or need this form in large print or in a different format, contact the agency for which you are completing this background check.

Keep these instructions for your records.

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

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.](#)

Developmental Disabilities Employer/Personal Support Worker/ Domestic Employee Information

Client & Employer/participant profile	
Name:	Date of birth:
Mailing address:	Phone number:
Physical address:	Services coordinator (Case worker):
Prime number:	Services coordinator (Case worker) phone number:

Personal support worker/domestic employee profile	
Name:	Social Security Number:
Provider Number:	Date of Birth:
Street Address:	Phone Number:
City, State ZIP:	Email:

Program: 49, 150, 151, or PC 20			
New hire: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Original hire date:	Hourly wage rate:	Monthly wage (if applicable):
Name of brokerage/CDDP: Marion County I/DDS		Start date:	End date:
<p style="color: cyan;">Please check the types of services provided by this employee. Please see details for each of the areas on the next page.</p>	<input type="checkbox"/> Community living supports <input type="checkbox"/> Homemaker/chore services <input type="checkbox"/> Non-medical transportation <input type="checkbox"/> Community inclusion supports <input type="checkbox"/> Other:	Shift during work days:	
		From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
		To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
		Regular scheduled days off:	
		<input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun	

RETURN COMPLETED DOCUMENT TO:
 Marion County Health & Human Services
 Intellectual/Developmental Disabilities
 3180 Center St Salem, OR 97301
 Email: DDPRocessing@co.marion.or.us
 Fax: 503-576-4593

Please check all of the services that your employee will provide. If an approved activity is not included, please write in the service in the "Other services provided" column.

Community living supports	Employee	Homecare/ chore services	Employee	Non-medical transportation (please check all that apply)	Employee	Community inclusion supports (List a sample of activities in the box below)	Employee	Other services provided by your employee (write in)	Employee
Eating	<input type="checkbox"/>	Giving and setting up medications	<input type="checkbox"/>	Drives your vehicle	<input type="checkbox"/>	Activities supporting independence and community inclusion	<input type="checkbox"/>	Create & Submit Service Delivered Entries (hours worked) using online eXPRS system.	<input checked="" type="checkbox"/>
Bathing	<input type="checkbox"/>	House-keeping chores	<input type="checkbox"/>	Escorts you in your vehicle	<input type="checkbox"/>	Individual choice of activities	<input type="checkbox"/>		<input type="checkbox"/>
Dressing	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	Escorts you on public transportation	<input type="checkbox"/>	Respite Services	<input type="checkbox"/>		<input type="checkbox"/>
Personal hygiene	<input type="checkbox"/>	Special diet/meal preparation	<input type="checkbox"/>	Drives you in their car	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Mobility	<input type="checkbox"/>	Shopping	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Socialization	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Community participation	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Communication	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Personal environmental skills	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Employee signature

Date

Employer/representative signature

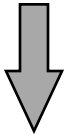
Date

RETURN COMPLETED DOCUMENT TO:
 Marion County Health & Human Services
 Intellectual/Developmental Disabilities
 3180 Center St Salem, OR 97301
 Email: DDPRocessing@co.marion.or.us
 Fax: 503-576-4593

MARION COUNTY CDDP PSW ENROLLMENT PROCESS

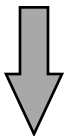
NEW PSW ENROLLMENTS MAY TAKE UP TO 3-4 MONTHS

STEP 1: FORMS REQUIRED – **DO NOT WORK**



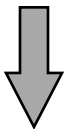
- FORMS REQUIRED TO BEGIN PROCESS: Employee Demographic Form, Background Check Information Form (CHC), Provider Enrollment Application & Agreement (PEAA), and Domestic Employee Information (0550).
 - Complete and submit forms in person to: 3180 Center St NE, Salem, OR 97301.
 - **ID must be presented, verified, and copied at this time.** (Front desk, 3rd floor)
- If requested, corrections that need to be made to any of the forms will be communicated by email from DD Processing.*

STEP 2: PSW CREDENTIALS PENDING – **DO NOT WORK** Approximately 8-12 weeks



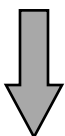
- All results will be sent by email.
- CHC RESULTS:
 - DENIED: PSW will not move forward in the process.
 - APPROVED: PSW will move forward
- PROVIDER NUMBER: An email will be sent from State of Oregon with PSW SPD (provider) number. Contact DD Processing when received.
- FINGERPRINTS (If requested): 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: PPL – **DO NOT WORK** Approximately 3 weeks



- **PUBLIC PARTNERSHIPS, LLC (PPL) FORMS**
 - Established EOR (Employer of Record)
 - DD Processing associates PSW to the individual/employer. This will prompt PPL to send PSW a packet of their forms. **Complete and return these forms to PPL.** This establishes the Employment Relationship.
 - New EOR
 - **PSW process will be placed on hold until the EOR process is complete.** Once EOR is established, see process for Established EOR above.
 - eXPRS User Enrollment Form to be completed and returned to eXPRS.
- NOTE:** Contact PPL for assistance with these forms or to check the status.
Phone: 1-888-419-7705 Email: PPLORFMAS-CS@pcgus.com

STEP 4: SERVICE AGREEMENT – **DO NOT WORK** Arrange with DD Processing



- PPL establishes the Employment Relationship and transfers the update to show in the State's eXPRS system.
- An email will be sent to you from DD Processing with instructions regarding signing a Service Agreement.
- Sign and return Service Agreement to DD processing

STEP 5: READY TO WORK

- Steps 1-4 are completed and verified at this time.
- **Please await an email to confirm that you are "Good to Go" and ready to work from DD PROCESSING.** Additional instructions and guides for eXPRS will be included.

This page intentionally left blank.

PSW Resource List



- **Marion County DD Processing – PSW Credentialing & Timesheet Processing**
 - o Phone: 503-540-2128
 - o Email: ddprocessing@co.marion.or.us (Preferred method of contact)



- **eXPRS User Accounts – Password or Account Lockouts, New Enrollments & Information Changes**
 - o Phone: 844-874-2788 Option #3
 - o Email: info.exprs@state.or.us

***Note: All locked accounts are unlocked daily



- **PPL – PPL Paperwork, Payment Status, Direct Deposits, W2 Changes & BetterOnline Accounts**
 - o Phone: 888-419-7705
 - o Email: pplorfmcs@pcgus.com



- **PSW Credentials – New or Renewing & Forms**
 - o Phone: 844-874-2788 Option #4
 - o Email: psw.enrollment@state.or.us
 - o PSW Forms may be found: <http://www.co.marion.or.us/HLT/DD/Pages/services.aspx>



- **Criminal Background Checks & Fingerprint Requests**
 - o Phone: 877-614-4364
 - o Email: customerservice@fieldprint.com



- **Oregon Home Care Commission – PSW Resources & Training Information**
 - o Phone: 877-867-0077
 - o Website: <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/Pages/index.aspx>
 - o New PSW Orientation & Training: <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/Pages/PSW-Orientation.aspx>
 - o PSW Registry and Referral System: <https://or-hcc.org/>



- **Local 503 SEIU (UNION)**
 - o Phone: 844-503-7348

Marion County DD Processing Frequently Asked Questions

Category: Personal Support Workers (PSW) Enrollment

How do I start the process of becoming a PSW?

The first step is to fill out and return a PSW New Enrollment packet. The packet includes a Criminal History Check (CHC) which needs to be submitted in person so that photo ID can be verified and copied.

Packets are available:

- Printed from: <http://www.co.marion.or.us/HLT/DD/Pages/services.aspx>
- Picked up from our office at 3180 Center St NE, Salem, OR 97301
- Emailed by sending a request to ddprocessing@co.marion.or.us or by calling DD Processing at 503-540-2128

How long does it take to get approved to work as a PSW?

Processing time can vary but may take 10 - 12 weeks depending on processing at the State level. Please make sure your forms are filled out completely and correctly to avoid processing delays. If corrections are needed, you will be notified by email.

How will I know when I'm approved to work?

Final approval to work depends on many items being completed (*Refer to the PSW Enrollment Process Flowchart*). You will first receive approval of your Criminal History Check, but this is only ONE piece of many and does NOT approve you to start working. A confirmation email will be sent to you and your Employer when you may begin working.

I'm already set up as a PSW; how do I find more clients?

Once you have a PSW SPD provider number and a current CHC, you may register with the Oregon Home Care Commission registry at <https://or-hcc.org>. Once you find an individual to work with, you will need to contact us for an "Adding a New Client" packet. You may NOT begin working until the paperwork has been completed (*Refer to the Adding a New Client Flowchart*). Processing time is dependent on how quickly the paperwork is received and returned.

Please note, the registry is run by Oregon Home Care Commission and is separate from the Marion County office. This is a great website designed to connect potential Employers and PSWs. PSWs can "advertise" themselves by creating a profile and Employers can then search all PSWs. Employers can also create a "Help Wanted" ad which PSWs can then browse and respond to.

Tip: When using the registry, enter LESS search criteria to bring up MORE results.

Do my PSW credentials expire? How do I renew?

Yes, PSW credentials expire after two years and are listed on the home page of your eXPRS login screen. There are two types of credentials that must be renewed: your CHC & your PSW SPD provider number which is your Provider Enrollment Application and Agreement (PEAA).

Renewal packets are available:

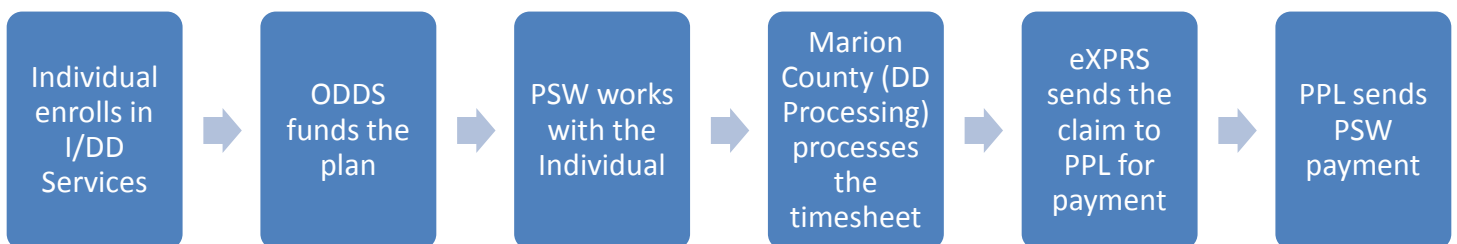
- Printed from: <http://www.co.marion.or.us/HLT/DD/Pages/services.aspx>
- Picked up from our office at 3180 Center St NE, Salem, OR 97301
- Emailed by sending a request to ddprocessing@co.marion.or.us or by calling DD Processing at 503-540-2128

Renewals must be submitted 70 to 90 days BEFORE your expiration date to allow for processing time and to avoid payment delays. If you fail to renew your credentials before they expire, you will NOT be approved to work and will NOT be authorized to receive pay.

Who are all these organizations?

It can be confusing in your role as a PSW to interact with many different organizations.

- **Marion County Intellectual/Developmental Disabilities & Marion County DD Processing (I/DD office or CDDP)** is the local program. We are your first contact with any questions you may have regarding services, eligibility, PSW and EOR enrollments, and eXPRS time entry.
- **Office of Developmental Disabilities Services (ODDS)** is the State level office. They control funding, rules, services throughout the State of Oregon, and contract with us to implement the program within our County.
- **eXPRS** is the State's online payment and time processing system.
- **Public Partnerships, LLC (PPL)** is a private organization that ODDS contracts with to manage PSW payroll. PPL issues PSW paychecks, W-2s, tax information, etc. on ODDS' behalf.
- **Oregon Home Care Commission (HCC or OHCC)** is a division of the Oregon Department of Human Services (DHS) which supports PSWs by defining qualifications, managing the registry, providing trainings, etc.



Category: Personal Support Workers Time Entry/Payroll

eXPRS isn't working – what do I do?

eXPRS is the State's system so there is very little that Marion County staff can do (we are users of this system just like you are). If the system is down or scheduled to be down, there may be a message on the login screen in red print.

I'm locked out of eXPRS – what do I do?

If you are locked out and need to reset your password, you will need to follow the instructions on the screen or contact eXPRS by calling 1-844-874-2788, option #3. eXPRS unlocks accounts twice a day (mid-morning and mid-afternoon) so you have the option of trying to log in again at a later time if you are not able to speak to someone.

How do I know you got my timesheet?

Timesheets are processed in the order that they are received and are normally done so within 24 – 48 hours. To confirm that your timesheet has been received, you can view the status of your time entries in eXPRS. If they move from "pending" status to "approved" status, your timesheet has been received and processed.

Confirmation of received timesheets are sent if timesheets are emailed to ddprocessing@co.marion.or.us. Confirmations are NOT sent for timesheets that are dropped off or faxed in. If you choose to email your timesheet, please make sure they are clear and legible as they are a part of the permanent record.

What is the "Service Goal" and "Progress Notes"?

These two sections on the timesheet are required for any timesheet submitted on or after 7/1/16. If either of these two sections are left blank, that timesheet will NOT be processed for payment.

Service Goal is the goal that you are working with the client to achieve as defined in the Service Agreement. Please check with your Employer if you are unsure of the service goal.

Progress Notes explain how you helped the person to meet their goals, and/or any other information that is relevant for the Service Coordinator to know.

Additional information can be found <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/Pages/psw-resources.aspx>

Something is wrong with my paycheck...

Please contact PPL directly regarding payment & direct deposit questions.

Category: Employer of Record (EOR)

I'm already set up as an EOR; how do I find more PSW's?

Create a profile on the Oregon Home Care Commission registry at <https://or-hcc.org>. Please note, the registry is run by Oregon Home Care Commission and is separate from the Marion County office. This is a great website designed to connect potential Employers with PSWs. PSWs can “advertise” themselves by creating a profile and Employers can then search all PSWs. Employers can create a “help wanted” ad which PSWs can then browse and respond to.

Once you find a potential PSW, the PSW will need to fill out an “Adding a New Client” packet. The PSW may NOT begin working until this paperwork is completed (*Refer to Adding a New Client Flowchart*).

Tip: When using the registry, enter LESS search criteria to bring up MORE results.

What is the role of an EOR?

The Employer is responsible for hiring, training, scheduling, and dismissing PSWs. The Employer is also responsible for ensuring PSWs are performing duties in alignment with the Individual's goals and Individual Service Plan (ISP). Employers must sign all timesheets which attest that the information on the timesheet is true and accurate. Being an Employer does NOT impact personal taxes.

What's the difference between using a PSW and using an agency?

When a client is authorized to receive in-home attendant care, the client/guardian may choose to receive that service by:

- Contacting an agency provider, and the agency will send their staff into the home to work with the individual.
 - It is the agency's responsibility to obtain client/guardian signatures on invoices and to submit them to Marion County DD Processing

AND/OR

- Become an Employer, and hire their own PSWs to come into the home to work with the individual.
 - It is the responsibility of both the PSW and Employer to ensure timesheets are complete, accurate (including signature of PSW and Employer) and submitted to Marion County DD Processing. PSWs are also responsible for entering their times into eXPRS.