

PSW Application - Deschutes CDDP

Applicant, two third party entities, ORCHARDS and Public Partnerships (PCG), manage the entire PSW application process - their application processing wait time is 2 - 3 months.

Because both entities require you to start your application with us, please proceed and follow instructions...

1. Complete and return this entire packet to: psw.timesheets@deschutes.org.
 Include in return email: front/back image of Driver License (government issued ID)
*When you return this packet, you've **NOT** completed your background check,*
 ORCHARDS requires further action from you, please keep reading...

2. After we send your returned forms to ORCHARDS, they email you the official/actual background check.
Because email service providers often auto-filter ORCHARDS address to spam/junk, ensure to save their email: noreply@innovativearchitects.com

First, Last Name:					
Driver license &/or government issued ID		Issuing State:	Number:	Exp date:	
Aliases/other names used:				DOB:	
Gender:	Male	Female	Both	Unknown/Not Specified	Other
Email:					
Physical, street address:					
City:			State:	ZIP code:	
Mailing address					
<input type="checkbox"/> same as physical If different, mailing address:					
City:			State:	ZIP code:	
Phone:					

During the last 5 years, have you been outside of Oregon for 60 days in a row or more?					
<input type="checkbox"/> Yes* <input type="checkbox"/> No *If yes , complete the following for each residence in the past 5 years:					
Date (mm/dd/yy)		City:	State:	Country:	Name(s) used at this residence
Start:	End:				

Tip if you're having trouble filling out this form and/or, e-signing - click/tap here to download a Adobe's free app, "Fill & Sign" to your device.

**Personal Support Worker (PSW)
Provider Enrollment Application and Agreement (PEAA)**
(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 - *Personal Support Worker (PSW)*

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)

Deschutes County CDDP

Submitting Brokerage/CDDP/CIIS

psw.timesheets@deschutes.org

Submitting Brokerage/CDDP/CIIS contact email

5. **Eligibility and continued participation:** Eligibility and continued participation as a PSW is conditioned on Provider's execution and delivery of this Agreement, any required certifications or trainings and the continued accuracy of that information. Provider must continue to meet all the eligibility requirements as stated in OAR 411-375-0020, subject to verification by DHS.
6. **Provider suspensions and payment recovery:** Failure to comply with the terms of this Agreement, ODDS rules, DHS and OHA rules, or failure of the application to be accurate in any respect, may result in inactivation of the Medicaid provider number, termination of this Agreement, and/or payment recovery pursuant to OAR chapter 411, division 375 and OAR chapter 407, division 120 rules.
7. **Statewide Registry and Referral System:** The Oregon Home Care Commission has an internet-based, statewide Registry and Referral System (RRS) to assist Recipients in finding qualified in-home providers. Provider understands that if Provider agrees to be referred to prospective client-employers (*Recipients*) through the RRS, Provider's contact information (*name, phone number, and provider number*) will be released to anyone seeking in-home services, and that if Provider does not want Provider's contact information disclosed, Provider will not be eligible for referral to prospective Recipients.

8. Provider signature

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

Print name of provider: _____

Signature of provider

Signature/Effective date