HEALTH & HUMAN SERVICES
DEVELOPMENTAL DISABILITIES SERVICES

Parent Personal Support Worker Packet Instructions

Welcome to Lane County Developmental Disability Services Personal Support Worker Enrollment Process

ODDS has received permission from CMS to support families of children under 18 with the most significant need by allowing parents to temporarily provide paid hourly supports to their children as Personal Support Workers (PSWs). Below outlines the process for Lane County

Please be sure to read these directions carefully!

In this packet, you will receive the following documents:

1. The Criminal History Check Form
2. The Provider Enrollment Application and Agreement form
3. Employer/PSW-Domestic Employee Form

Please fill out each document completely. Missing information may cause a delay in processing your paperwork.

Parents that have never been a PSW that are the **current** Employer of Record will need to contact your Service Coordinator to complete **the Employer of Record Change Form**. You are **not** able to be the Employer of Record and your child's PSW at the same time.

Parents that are currently active PSWs that are not the Employer of Record for their child will need to fill out **Form 3**.

You may submit the completed forms to our office. Please ensure all copies are clear, readable, and contain all information and signatures. These can be either left in our drop box at our office or sent via email to: LaneDDSCrims@lanecountyor.gov

New PSWs will need to have their ID scanned and verified as per state regulations. Our staff will be available to scan and verify your ID Tuesdays from 9:00am – 11:00am and Thursday 2:00pm – 4:00pm at our main lobby, you can at this time drop your paperwork in our dropbox.

IMPORTANT NOTES:

- Please do not begin working until you receive a formal authorization to start from our office.
- Please ensure that all paperwork is completed legibly and thoroughly and signed where appropriate
- Please ensure that all information is consistent on each document. Any difference in name, address or other information can result in a delay to your certification.

If you have any questions feel free to contact our office at 541-682-3695 or LaneDDSCrims@lanecountyor.gov.

Thank you for your continued support of I/DD individuals in our community!

LCDDS PSW Criminal History Check Request

Reason for Criminal History Check ☐ New ☐ Renewal

Name (as it appears on your ID)

First **Middle** **Last**

Social Security Number ____ - ____ - ____ **Date of Birth** ____ - ____ - ____

Gender ☐ Female ☐ Male ☐ Other ☐ Unknown/Not Specified

Cell Phone (____) ____ - ____ **Home Phone** (____) ____ - ____

Email ____

Permanent/ Physical Address

Address ____

City ____ **Zip Code** ____

☐ My mailing address is the same as my physical address

Mailing Address

Address ____

City ____ **Zip Code** ____

Prior Names Please list any prior names including maiden names, married names, name changes, and any name that you have used or been known by. These are required for the background check to be complete and accurate.

Prior Addresses If you have lived out of state for more than 60 days in the past 5 years, please list the dates and city and states you have lived in.

From (Year)		**State**	
To (Year)		**City**	
From (Year)		**State**	
To (Year)		**City**	
From (Year)		**State**	
To (Year)		**City**	
From (Year)		**State**	
To (Year)		**City**	

Identification - Please provide a copy of the front and back of your ID

☐	Oregon State Issued Driver's License	**Document ID #** _____ **Expiration Date** _____
☐	Oregon State Issued Identification Card	**Document ID #** _____ **Expiration Date** _____
☐	Non-Oregon State Issued Driver's License State _____	**Document ID #** _____ **Expiration Date** _____
☐	Non Oregon State Issued Identification Card State _____	**Document ID #** _____ **Expiration Date** _____
☐	Passport	**Document ID #** _____ **Expiration Date** _____
☐	Visa	**Document ID #** _____ **Expiration Date** _____
☐	United States Armed Forces ID	**Document ID #** _____ **Expiration Date** _____
☐	Other _____	**Document ID #** _____ **Expiration Date** _____

Position Information

Position will work with: ☐ Adults ☐ Children

If working with adults this position will require driving ☐ Yes ☐ No

Please return completed forms to
LaneDDSCrims@lanecountyor.gov

IMPORTANT INFORMATION

After your criminal history check is submitted to the state, you will be receiving an email from the **Background Check Unit (bcu.orchards@dhsoha.state.or.us)** to electroncially authorize the running of the background check.

Your authorization must be completed within 21 days of recieveing the email from the Background Check Unit. If it is not completed within that timeframe your criminal history check will be closed and will need to be completed again.

If you do not receive an email for the consent please contact our office.

DHS
Oregon Department of Human Services
Seniors and People with Disabilities

Developmental Disabilities Employer/Personal Support Worker/ Domestic Employee Information

Please Print and Write Clearly

Personal Support Worker Information

Name

Last First Middle

Social Security Number

Residential Address

Address City Zip Code

Date of Birth

(MM/DD/YYYY)

Mailing Address If different from Residential Address

Address City Zip Code

Phone

Is this a Mobile Number ☐ Yes ☐ No

Email

Client Information

Name

Last First Middle

Client Date of Birth

(MM/DD/YYYY)

Prime Number (if known)

Employer Information

For clients 17 and younger, this may be the Parent or Guardian
For adults 18 and older this may be the client, Guardian or other designated person (Employer of Record)

Name

Last First Middle

Date of Birth

(MM/DD/YYYY)

Residential Address

Address City Zip Code

Phone

Is this a Mobile Number ☐ Yes ☐ No

Mailing Address If different from Residential Address

Address City Zip Code

Email

RETURN COMPLETED DOCUMENT TO:

Lane County Developmental Disabilities Services
125 E 8th Eugene, OR 97401
Fax: (541) 682-3879

Personal Support Worker Provided Services

Please check all the services that your employee will provide. If an activity is not included, please add it in the "other services provided" column.

Community Living Support

- ☐ Eating
- ☐ Dressing
- ☐ Mobility
- ☐ Community Participation
- ☐ Communication
- ☐ Bathing
- ☐ Personal Hygiene
- ☐ Socialization
- ☐ Personal Environmental Skills

Homecare/Chore Services

- ☐ Giving and Setting up Medications
- ☐ Housekeeping Chores
- ☐ Shopping
- ☐ Special Diet/Meal Preparation
- ☐ Laundry

Non-medical Transportation (Please check all that apply)

- ☐ Drives your vehicle
- ☐ Escorts you in your vehicle
- ☐ Drive you in their car
- ☐ Escorts you on public transportation

Community Inclusion Supports (list a sample of activities in the boxes below)

- ☐ Activities supporting independence and community inclusion

- ☐ Individual choice of activities

- ☐ Respite Services

Other Services provided by your employee (write in)

- ☐ Create & Submit hours worked using online eXPRS system
- ☐ Utilize EEV for logging in and out of work shifts
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

PSW/Employee Signature _____ Date _____

Employer/Representative Signature _____ Date _____

DHS | Oregon Department of Human Services
INTELLECTUAL/DEVELOPMENTAL DISABILITIES

I/DD PERSONAL SUPPORT WORKERS ONLY

Print form | 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

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