

## Referral Agent Registration Application

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1. Name of Referral Agent (legal entity as registered with Secretary of State, attach additional sheets of paper as needed):
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2. Physical address of Referral Agent:
- City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_
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3. Telephone number: \_\_\_\_\_ 7. Fax number: \_\_\_\_\_
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4. Mailing address (if different from above):
- City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_
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5. Referral Agent Website: \_\_\_\_\_
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6. Does Agent website contain a link to state agency website listing facility complaints?  Yes  No  
(If Yes, proceed to line 7.) ([Facility Complaints](#))
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- 6b. Does Agent provide clients with web address to state agency website listing facility complaints, in writing?  
 Yes  No ([Facility Complaints](#))
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7. Type of action:  New agency (\$750.00)  Renewal (\$500.00)  Ownership change (\$750.00)  
 Responsible person change (no fee)  Referral Agent name change (no fee)
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8. Name of responsible person: \_\_\_\_\_ 9. Title: \_\_\_\_\_
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9. Telephone number: \_\_\_\_\_ 10. Email address: \_\_\_\_\_
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11. Mailing address (if different from above):
- City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_
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12. Type of business:  Individual  Partnership  Corporation  LLC  
 For profit  Not for profit (NFP). If NFP, list IRS code: \_\_\_\_\_
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13. Basis of types of facilities that this agency provides referrals?
- Contracted  Non-Contracted  
 Adult Foster Home  Medicaid Contracted  
 Assisted Living Facility  Independent Living  Memory Care  
 Residential Care Facility  Other: \_\_\_\_\_
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14. List all employees having direct contact with, (A completed background check, [MSC 0301QED](#) must be attached for each listed employee in accordance with OAR 411-058-0070.

Name	Title

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15. Required attached documents (*check box*):

- Attachment 1:** Disclosure Form (An example disclosure form and advisory statement are located [\(web link\)](#))
- Attachment 2:** Line 17 Continuation sheet, if applicable
- Attachment 3:** Criminal History Background Check ([MSC 0301QED](#)) (One for each in line 17)
- Attachment 4:** Proof of insurance (evidence of a minimum \$1,000,000.00 in general liability insurance)
- Attachment 5:** Registration fee (refer to line 7)     Initial: \$750.00     Renewal \$500.00

16. List any facilities with the State of Oregon in which the Referral Agent may have an ownership interest, or is owned by an immediate family member. In none, enter N/A for non-applicable.

Facility Name	Facility Location

I attest that I have examined this application and all attachments and to the best of my knowledge and belief this information is true, correct, and complete. I will notify the Department of any changes in this information within 30 days of such change. I have read, understand and complied with instructions for this application. Inaccurate information may result in delay of registration. False or misleading information may be subject to registration denial, suspension, cancellation, and/or civil penalty of \$5000.00.

<p>Registration does not constitute recommendation or endorsement by the Department of Human Services. Registration is not evidence of the accuracy or completeness of information in this application.</p>	<p><b>SOQU use only</b></p> <p><input type="checkbox"/> Fee paid</p> <p><input type="checkbox"/> Reviewed</p>
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