

Patricia Baxter
Authorized Signature

Number: APD-AR-14-023
Issue Date: 4/18/2014

Topic: Developmental Disabilities

Due Date:

Subject: Provider Enrollment Process for New DD Individual In-Home Services
Providers for eXPRS Plan of Care

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Aging and People with Disabilities | <input type="checkbox"/> Office of Developmental Disabilities Services(ODDS) |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Other (<i>please specify</i>): DD Brokerage Directors, CDDP Service Coordinators, Brokerage Personal Agents, ODDS Central Office Staff, SPD Provider Relations Unit staff |
| <input checked="" type="checkbox"/> County DD Program Managers | |

Action Required: Effective the date of this transmittal, CDDP and Brokerage staff shall submit to DHS the required provider enrollment information, utilizing the designated ODDS forms and process, to facilitate the enrollment of new individual in-home services providers (including DD Personal Support Workers, Independent Contractor Personal Support Workers, and other individual in-home providers) for providers not yet enrolled to the SPD provider database. Successful provider enrollment to the SPD provider database is required in order to be utilized as a provider for eXPRS Plan of Care.

The ODDS required forms, process flow outline and instructions for New In-Home Provider Enrollment are included with this transmittal.

Reason for Action: As ODDS transitions to using eXPRS Plan of Care (POC) functionality for the service authorization and payment of ODDS funded In-Home services to individuals with I/DD, individual providers employed to deliver these services must first be successfully enrolled to the SPD provider database, have completed the credentialing process and have an SPD Provider ID number assigned. For providers not yet enrolled to the SPD provider database, their enrollment and credential information is required. CDDPs and Brokerages, as ODDS contracted

entities that facilitate and authorize those in-home services for I/DD individuals, assisting in the provider enrollment and credentialing process is essential.

Field/Stakeholder review: Yes No

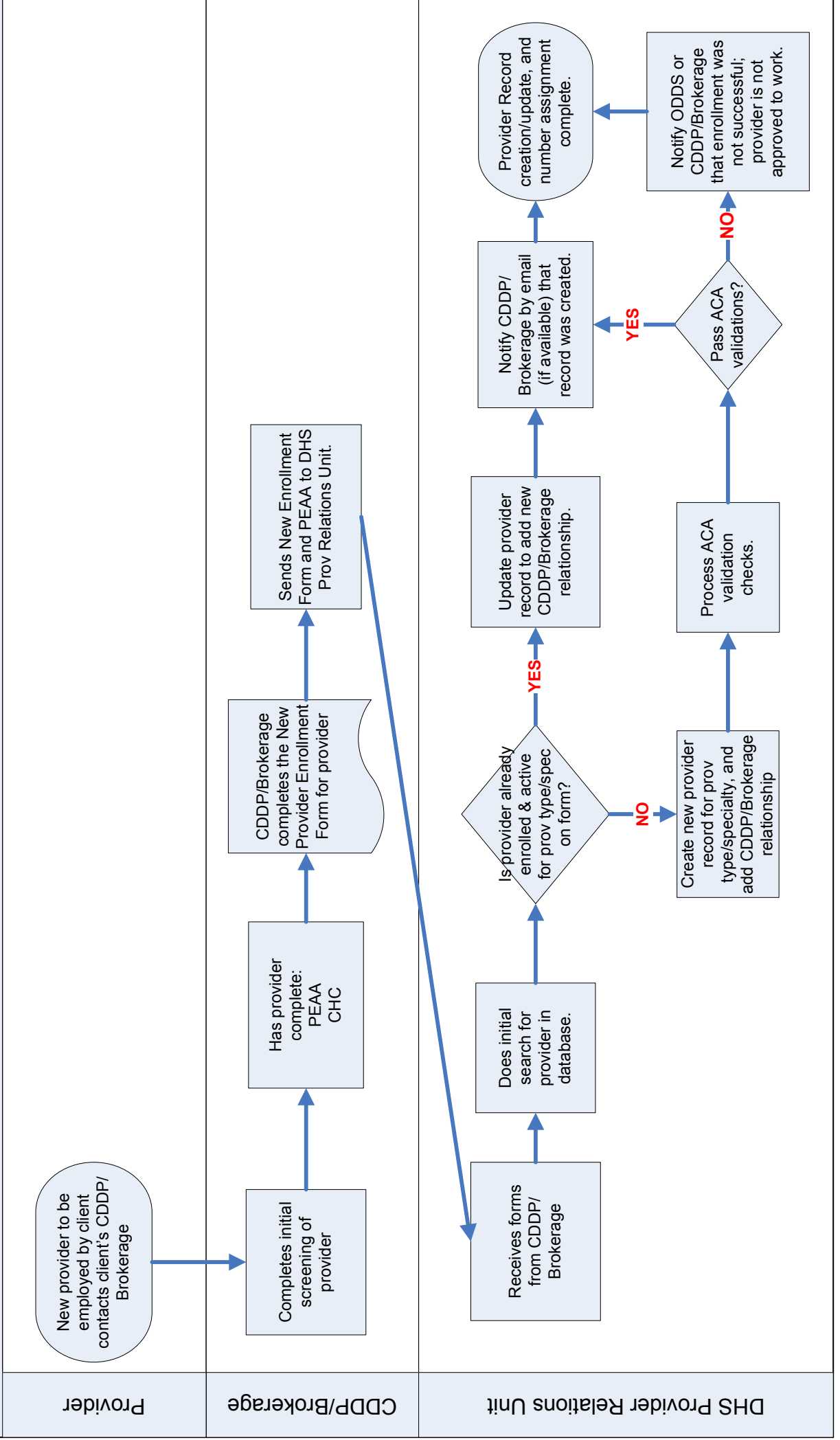
If yes, reviewed by:

If you have any questions about this action request, contact:

Contact(s):	Julie Harrison, DD Payment Systems & Program/Policy Specialist		
Phone:	desk: 503-947-4224 cell: 503-569-6357	Fax:	
E-mail:	Julie.a.harrison@state.or.us		

PROCESS FLOW – New PSW/Individual In-Home Provider Enrollment

v4; 4/7/2014





Instructions for Completing and Submitting New DD PSW or Individual In-Home Provider Enrollment Information Form for NEW PROVIDERS

When an individual with I/DD identifies someone to become their In-Home services provider (either a DE/PSW or IC/PSW) the provider must be enrolled to the DHS Provider Database and have a DHS/SPD provider number assigned for the appropriate provider type/specialty for DD In-home services in order to be authorized to provide services and receive payment.

The Brokerage and/or CDDP will first meet with the provider to gather the necessary information and begin the provider credential and enrollment process. The attached form will assist to communicate to DHS the required provider information needed to facilitate enrollment and credentialing of that provider in the DHS Provider Database.

The CDDP and/or Brokerage must complete the attached **NEW DD PSW or Individual In-Home Provider Enrollment Information** form and submit it to DHS, along with a copy of the signed PEAA form, for the provider(s) selected to work for a client for whom they authorize/coordinate services.

NEW DD PSW or Individual In-Home Provider Enrollment Form Instructions:

- **Section 1: Identifying Information**
Complete this section thoroughly **for ALL providers**. This information is required, even for providers who may be incorporated. We must verify the identity of the individual/owner.
- **Section 2: Provider Incorporation, Partnership or Other Information**
Complete this section thoroughly for providers who are incorporated as a business, such as an LLC.

- **Section 3: Address Information**

Complete this section thoroughly **for ALL providers** requesting enrollment.

- **Section 4: Provider Credential Information**

Complete this section thoroughly **for ALL providers** requesting enrollment.

1. **CHC Fitness Determination:** An approved CHC fitness determination is required for all providers for successful enrollment/credentialing and number assignment, and must be renewed every 2 years. In most cases, the CHC fitness determination approval may be applicable to the provider's services statewide, but there may be situations where a new determination is needed.

For example, if the current CHC approval is for the type "adult" and the provider will now be working with children with I/DD, a new determination for the type "child" will be required, even if the previous "adult" is less than 2 years.

Also, if "restricted" is selected as the CHC level that means the provider is restricted to only working with specific individuals. The client prime number(s) that those client(s) the provider is restricted to must be included.

2. **Enrollment Agreement:** Each provider must sign the ODDS Provider Enrollment Application & Agreement form for successful enrollment/credentialing and number assignment, and must be renewed every 2 years.

A copy of the provider's signed PEAA must be submitted with this new enrollment form.

- **Section 5: Associated or Credentialing CDDP or Brokerage**

Complete this section thoroughly **for ALL providers** requesting enrollment. Please list the CDDP and/or Brokerage name that the provider will be associated with.

Once the new enrollment form is completed, submit the form AND a copy of the provider's signed ODDS Provider Enrollment Application & Agreement (PEAA) in one of the following ways:

By Email:

Send a request for a secure email to spd.providernumber@state.or.us.

When received, DHS will reply back with a secure email. When the secure email is received, click reply to that secure email, attach the New Enrollment form and PEAA, and then send.

By Fax:

Fax completed New Enrollment form and PEAA to: **503-947-5357**

By US Mail:

Mail the completed New Enrollment form and PEAA to:

**Provider Relations Unit
PO Box 14960
Salem, OR 97309-5045**

→ ***PLEASE NOTE***: There are other enrollment forms and activities that may be needed for the provider, ***but are separate*** from the enrollment process outlined above.

Other "Enrollment" processes include:

- **Fiscal Intermediary Provider Enrollment**: this enrollment is required, and includes all the financial and other fiscal enrollment forms (such as W4, direct deposit, etc) needed for the provider to be set up with the Fiscal Intermediary to receive their payments. *****This enrollment processes must be completed BEFORE the provider is able to receive payment, and should be completed prior to any service authorization for the client that identifies/uses the provider.***
- **eXPRS User Enrollment**: this enrollment is optional, but is highly encouraged. This enrollment is to enable the provider to have access to the eXPRS Payment system to directly submit their claims for services delivered to the clients who employ them. These claims in eXPRS (as of 7/1/14) are

what will generate the payment the provider will receive from the Fiscal Intermediary.

- **Oregon Home Care Commission Registry Enrollment:** this is to set up the provider's profile (which acts somewhat like their resume') on the OHCC Registry and Referral System. This enrollment is optional for the provider, but must be completed ***IF*** the provider wants to be active in registry searches for other potential PSW employment opportunities.



**NEW DD PSW or Individual In-Home Provider
Enrollment Information Form
Office of Developmental Disability Services
For Initial Enrollment Only**

Section 1: Identifying Information

Disclosure of Social Security Number and Date of Birth is required pursuant to 42 USC 405(c)(2)(i) for the purpose of establishing identification, 42 CFR 455.104 for the purpose of exclusion verification, and 26 CFR 301.6109-1 for the purpose of reporting tax information.

Provider Information

Individual Name (full legal name required):

1. Last : First : Middle Initial :

2. Individual's **Date of Birth (required):** / /

3. Doing Business As (DBA) Name:

Social Security Number (SSN) (required):

4. _____

Other **Tax ID Number (TIN)** if different than SSN:

5. **Provider's Email Address:**

6. **Provider Type:** Using addendum list on page 3, enter the number(s) for the provider type(s) the provider to be enrolled as:

Is the provider an active DHS Provider in Oregon? Yes No

7. If Yes, please indicate the provider's SPD Provider ID number(s).

Is the provider an active Medicaid Provider in another state? Yes No

If Yes, please indicate your Medicaid Provider ID number, state and contact information.

Medicaid Provider ID number: State:

8. **Has this person been convicted of a criminal offense related to this person's involvement in any program under Medicare, Medicaid or Child Welfare?** Yes No

Section 2: Corporation, Partnership or other information

If the Provider is incorporated, complete this section.

1. **Official IRS Business Name:**

2. **Doing Business As (DBA) Name:**

Business Type - Indicate all that apply:

3. Individual Practitioner Trust
 Sole Proprietorship LLC
 Partnership LLP
-

4. **Employer Identification Number (EIN) or Tax Identification Number (TIN):**

5. **Provider Type:** Using the addendum list on page 3, enter the provider type(s) the provider is to be enrolled as:

Is the provider an active DHS Provider in Oregon? Yes No

If Yes, please indicate the provider's SPD Provider ID number(s):

6. **Is the provider an active Medicaid Provider in another state?** Yes No
If Yes, please indicate your Medicaid Provider ID number, state and contact information.

Medicaid Provider ID number:

State:

7. **Has this person been convicted of a criminal offense related to this person's involvement in any program under Medicare, Medicaid or Child Welfare?** Yes No

Section 3: Address Information

Complete all applicable information. If there is additional address/contact information, please list on an attachment.

1. **Primary Business Address:**

Street or PO Box (include Room/Suite):			
City:	State:	Zip:	County:
Phone:	Cell:		Fax:

2. **Mailing Address** (if different than primary business address):

Street or PO Box (include Room/Suite):			
City:	State:	Zip:	County:
Phone:	Cell:		Fax:

Section 4: Provider Credential Information

Date of approved **CHC Fitness Determination:**

1. **Level of CHC:** Career Restricted; to client prime:

Type of CHC Approval: Adult Seniors Child

Date Provider signed the **ODDS Provider Enrollment Application & Agreement**

2. (PEAA) Form *(must include copy of signed PEAA with this form):*

Section 5: Associated or Credentialing CDDP or Brokerage

Check the box and then **ENTER THE NAME** of the CDDP(s) and/or Brokerage(s) that the provider is associated to. List all that apply:

CDDP:

Brokerage:

DHS/CIIS Program:

Addendum: DHS ODDS PSW & Individual In-Home Provider Types

Refer to this list to enter the provider type information for the provider as requested in Sections 1 and/or 2 on this form.

Provider Type Number	Provider Type Description
84-800	DD State Plan Personal Care (SPPC) PSW Provider
84-801	CIIS PSW Provider
84-803	DD PSW Provider (Domestic Employee)
74-712	Independent Contractor (IC) Provider (not PSW)
74-734	Independent Contractor (IC) PSW Provider
74-749	IC DD Employment Development/Discovery Specialist
75-751	Domestic Employee (DE) Provider (not PSW)
83-710	Behavior Consultant
83-711	Socio-Sexual Behavior Consultant
93-942	Brokerage Certified Service Agency In-Home Provider