



# Client Employed In Home Services Provider Enrollment

SHADED AREAS TO BE COMPLETED BY SPD ONLY. PLEASE PRINT OR TYPE

1. Last Name, First Initial		Provider Number		Name Ind.	
2. Street Address, City State Zip					
3. Mailing Address (If different) City, State, Zip					
4. Phone Number (     )     -		5. Social Security Number       -		6. Date of Birth-MM/DD/YYYY /     /	
FIPS		Prov. Type		7. Date Start Work	

**AGREEMENT:**

This Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services (DHS), Seniors and People with Disabilities Division (SPD), Division of Medical Assistance Programs (DMAP) , and \_\_\_\_\_ (Provider) regarding payment by DHS for prior-authorized publicly funded in-home services as defined in Oregon Administrative Rules 411-030-0002 through 411-030-0090 (In-Home Support Services), OAR 411-031-0020 through 411-031-0050 (Homecare Workers Enrolled in the CEP Program), OAR 411-032-0000 through 411-032-0044 (Oregon Project Independence), and OAR 411-034-0000 through 411-034-0090 (State Plan Personal Care), furnished by Provider to persons eligible ("Recipients") for service assistance through DHS, SPD or an Area Agency on Aging (AAA) or other DHS contractor.

- A. **Compliance with applicable laws:** The Provider agrees to adhere to federal, state and local laws and regulations including the administrative rules described in the above paragraph. Hereinafter any reference to DHS also includes and represents any of its Divisions, local offices, Area Agencies on Aging, or other contractors that enroll Providers who deliver services to Recipients of DHS programs. The Provider agrees to adhere to the provisions of the provider guide appropriate to the Provider's service category, including the Client-Employed Provider Program (CEP) Homecare Workers' Guide (publication 9046a).
- B. **Terms:** The Provider understands that the terms and conditions of this enrollment apply only to services provided to Recipients of public assistance from the Oregon Department of Human Services. DHS will make payment to the Provider on behalf of the Recipient (employer) for all publicly funded in-home services. This payment will be considered full payment for the services rendered under DHS' programs. Under no circumstances is the Provider to demand or

receive additional payment for these DHS-covered services from the Recipient, the Recipient's family or any other source.

- C. Payment and Claims Processing:** DHS agrees to process properly completed claims received for prior-authorized services. In accordance with OAR 410-120-1300 and 411-031-0040, all claims for service must be submitted within 12 months of the date of service or will not be paid. The Recipient (employer), or his or her representative, must sign all claims (vouchers) for payment prior to the claim being submitted for processing. Provider must not claim payment for services not provided. Payment must not be claimed for services delivered by any other individual.
- D. Recipient Eligibility:** Any payment for services provided to ineligible Recipients is the sole responsibility of the Provider. Payment by DHS will not be made on behalf of ineligible Recipients.
- E. Recordkeeping; Access; Confidentiality of Recipient's Records:** Provider is responsible for the completion and accuracy of (1) financial and timekeeping records and all other documentation regarding the specific services for which payment has been requested, and (2) all claims submitted by Provider. Provider shall furnish requested documentation to DHS, the local SPD/AAA office, 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. A Recipient's records are confidential and may be given only to the Recipient, or to others with the Recipient's prior written consent, or for purposes directly connected with the administration of the public assistance laws.
- F. Active Enrollment:** By signing this enrollment, the Provider indicates that he or she is available and able to provide services to one or more Recipients eligible for publicly-funded in-home services in Oregon. The provider enrollment will be inactivated if services are not authorized or paid during a twelve month period. Following inactivation, the Provider may reapply for enrollment in the Client-Employed Provider Program if he or she wants to provide services to DHS Recipients.
- G. Employment Relationship:** The Provider agrees that he or she is enrolling as a Homecare Worker, Personal Care Attendant or Personal Care Services Provider to provide services to one or more Recipients eligible for services through DHS. The Provider understands that he or she is not employed by any Division of DHS nor by any AAA and shall not for any purposes be deemed to be an employee of the State of Oregon or AAA whether or not DHS assists the Recipient (employer) in selecting the Provider or exercises any direction or control over the authorized services, or the provider enrollment. The Recipient (employer) carries primary responsibility for locating, interviewing, and hiring his or her own employees. Provider enrollment does not constitute a guarantee of work. The terms of the employment relationship are the responsibility of the Recipient (employer) to establish at the time of hire. Providers employed by the Recipient to deliver in-

home services are domestic service employees and therefore not subject to minimum wage or overtime protections under state and federal laws. Such providers are non-subject workers under ORS 656.027 (1) and ORS 411.590.

- H. Termination:** DHS may terminate this Enrollment Agreement at any time by written notice to the Provider. Provider shall send any termination notice to the local SPD/AAA office where he or she enrolled, or may send the notice to SPD Provider Payments Unit, 500 Summer Street NE, E12, Salem, Oregon 97301-1079.
- I. Eligibility and Continued Participation:** Eligibility and continued participation in the Client-Employed Provider Program is conditioned on Provider's execution and delivery of the application and required certification, and the continued accuracy of that information. Provider must continue to meet provider enrollment qualifications and cooperate with re-enrollment procedures including criminal history checks when requested by DHS. The information disclosed by Provider is subject to verification by DHS. This information will be used for purposes related to the administration of the Client-Employed Provider Program.
- J. Provider sanctions and payment recovery:** Failure to comply with the terms of this Enrollment Agreement, SPD rules and the Division of Medical Assistance Program's rules, or failure of the application or certificate to be accurate in any respect may result in sanctions, termination of the agreement, or payment recovery pursuant to OAR 411-031-0020, OAR 411-031-0040 through 411-031-0050, OAR 411-034-0050 and 411-034-0055, OAR 411-020-0000 through OAR 411-020- 0130, OAR 411-021-0000 through OAR 411-021-0025, 410-120-1397 through 410-120-1700, subject to Provider appeal rights described in OAR 411-031-0050 for Homecare Workers, OAR 411-034-0055 for Personal Care Attendants, and OAR 410-007-0200 through 410-007-0380 when based upon a criminal history check.
- K. Statewide Registry and Referral System:**  
The Oregon Home Care Commission has an internet-based, statewide Registry and Referral System (RRS) to assist seniors and individuals with physical disabilities to find qualified in-home providers. I understand that if I agree to be referred to prospective client-employers through the RRS, my contact information (name, phone number, and provider number) will be released to anyone seeking in-home services.

I agree to have my contact information released through the RRS: (Select one option)  
Yes  No

**PROVIDER:** By signing this Enrollment Agreement you acknowledge that you have read the Enrollment Agreement, understand the terms of the Agreement, and agree to be bound by the terms and conditions of the Agreement.

8. Signature (must be signed by Provider)	9. Date
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