



NorthWest Senior & Disability Services

5010 E 3rd Street Tillamook, OR 97141

Telephone: (503) 842-2770 Toll Free: 800-584-9712 Fax: (503) 842-6290

Homecare Worker Background Check Renewal

Dear Homecare worker:

It is time to renew your Home Care Worker Credential.

You must complete a Background check to renew your credential (provider number). **You must complete and return forms prior to 70 days of expiration date, if you fail to do so, it could result in termination and/or having to reapply to become an HCW.**

The renewal form is enclosed for you to complete along with a new Client Employed in Home Services Provider enrollment agreement.

*****An unexpired official ID is required for processing*****

*****Please attach a copy of your state or federal ID*****

Once you have completed the packet, you can email your ID and renewal documents to NWSDS.HCC@nwds.org

Or mail to:

NWSDS

5010 E 3rd Street

Tillamook, OR 97141

Once we receive and process the renewal form **you will receive an email from bcu.orchards@odhsoha.oregon.gov, you must complete the email disclosure to start your background check.** (Please check your spam and junk folders as well).

For questions regarding your renewal, please call 503-842-2099.

Sincerely,

HCC Administrative Assistants

Please include a copy of your unexpired official ID as required for processing

ORCHARDS RENEWAL

Oregon Criminal History & Abuse Database System

HCW Background Check Renewal Form

You will receive an email from bcu.orchards@odhsoha.oregon.gov and you will need to click the link and complete the disclosure portion to start the background check process.

Please complete the following information to renew your provider number.

Please print all the information legibly below.

*Provider Number: _____

*Complete full name (legal name as it appears on unexpired State ID):

*Social Security #:

*Date of birth (MM/DD/YYYY):

*Gender (check or circle one):

Male Female Unknown/Not specified Other Both

*Phone Number: _____ Phone Type (home, mobile, etc.): _____

*Residential Address:

Street: _____ Apt#: _____

City: _____ State: _____ Zip code: _____

*Mailing Address (if different than above):

Street: _____ Apt#: _____

City: _____ State: _____ Zip code: _____

*Email Address (print legibly):

*Prior names and aliases:

***You will receive an email from bcu.orchards@odhsoha.oregon.gov and you will need to complete your portion of the background check online to start the background check process. You only have 21 day to complete it or it will close*



Homecare Worker (HCW) Provider Enrollment Application and Agreement

This Homecare Worker (HCW) Medicaid Provider Enrollment Application and Agreement explains how to do the following:

- Enroll as a provider with the Oregon Department of Human Services (ODHS) Aging and People with Disabilities (APD) Program and set out HCW compliance obligations
- Update enrollment information, and
- Receive a provider number.

Note: Providers must have a provider number to be paid for providing services to Medicaid-eligible individuals in Oregon. Federal Medicaid and state funds pay for these services.

You can get this document in other languages, large print, braille or a format you prefer. Contact APD Provider Relations Unit at 800-241-3013 or email HCW.Enrollment@dhsosha.state.or.us. We accept all relay calls or you can dial 711.

Provider name

Your full legal name

(as listed on your current Social Security card, including suffix after first name, such as Jr.):

First: _____ Middle initial: _____ Last: _____

Aliases or other names used:

First: _____ Middle initial: _____ Last: _____

First: _____ Middle initial: _____ Last: _____

Provider type requested (mark all that apply):

- New HCW enrollment (73-737)
- HCW provider number renewal
Provider number: _____
- HCW re-enrollment (if provider number has been closed longer than 30 days)
Provider number: _____
- HCW name change
Provider number: _____ Branch number: _____

Providers must disclose their Social Security number (SSN). SSNs are required:

- To establish your identity [per 42 USC 405(c)(2)(C)(i)]
- To verify you are not excluded from being a provider [per 42 CFR 455.104 and 455.436], and
- To report tax information [per 26 CFR 301.6109-1].

ODHS 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 you consent to entering your SSN into ORCHARDS (background check system) to link to previous background check approvals? Yes No

Do not leave any area of this section blank. If the form is not complete, your application will be denied.

Street address: _____ City: _____ State: _____

ZIP code (+4): _____ County: _____

Mailing address (if different from above): _____

City: _____ State: _____ ZIP code (+4): _____

County: _____

Date of birth: _____ SSN: _____

Phone number: _____ Email address: _____

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

Do you now have or have you ever had any other state Medicaid, Medicare or other ODHS, Oregon Health Authority (OHA), APD, Office of Developmental Disabilities Services (ODDS) or OHA Health Systems Division (OHA-HSD) provider numbers? Yes No

If yes, list provider number(s) here: _____

Have you lived outside of the state of Oregon within the last five years? Yes No

If yes, enter information in table below:

Year		City	State	Country	Name(s) used at this residence
Start	End				

Gender identity — How do you identify? (*Check all that apply.*)

- Woman Man
- Non-binary, agender, gender non-conforming or another gender identity
- Prefer not to disclose

Do you consider yourself transgender?

- Yes No Prefer not to disclose

Language

What languages, including American Sign Language, do you speak? (*Choose all that apply.*)

I speak _____

and also speak _____.

I speak another language (*enter language here*): _____

What languages do you read? (*Choose all that apply.*)

I read _____

and also read _____.

I read another language (*enter language here*): _____

Race and ethnicity — How do you identify? (*Check all that apply.*)

- | | |
|--|--|
| <input type="checkbox"/> African | <input type="checkbox"/> Latino/Latina/Latinx |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> More than one race |
| <input type="checkbox"/> Arab, Middle Eastern | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Prefer not to disclose |

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Homecare worker (HCW) provider enrollment agreement

This HCW Provider Enrollment Application and Agreement (*referred to as Agreement*) describes the relationship between the state of Oregon, Oregon Department of Human Services (ODHS), Aging and People with Disabilities (APD), Oregon Health Authority (OHA) and the provider regarding payment by ODHS or entities funded and authorized by ODHS to pay for prior-authorized, publicly-funded in-home services provided to an eligible consumer-employer by an HCW.

Please review this Agreement carefully before signing. It outlines your obligations as a Medicaid provider in Oregon. Failure to follow this Agreement and obligations may result in the termination of your provider number and enrollment or other consequences.

Compliance with applicable laws

Provider understands and agrees that:

- A. Provider shall comply with federal, state and local laws and regulations related to items and services under this Agreement. This includes but is not limited to Oregon Administrative Rules (OAR) 407-120-0325 (*compliance with federal and state statutes*).
- B. If a court decides any term or provision of this Agreement is illegal or in conflict with any law, this Agreement's remaining terms and provisions shall remain in effect. The rights and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be invalid.
- C. Failure to comply with the terms of this Agreement or any applicable ODHS rules may result in termination or deactivation of provider's provider number. Provider may have appeal rights per OAR 411-031-0050 (Homecare workers enrolled in the Consumer-Employed Provider Program). Provider is a mandatory reporter per ORS 419B.005 to 419B.050 and ORS 124.050 to 124.095. Provider is required 24-hours per day, seven days per week to report abuse or suspected abuse of:
 - A child,
 - An older adult,
 - A resident of a nursing facility, or
 - An individual receiving mental health or intellectual/developmental disability services.

Failure to report abuse or suspected abuse is punishable by law and may result in the termination of the provider's enrollment.

- D. If provider provides service-related transportation services or travels directly between consumers' homes in the same day, provider must have and maintain a valid driver's license and automobile insurance coverage, as required by law. Provider is required to give ODHS proof of automobile insurance coverage every six months, or sooner if coverage renews. Provider understands service-related transportation or travel time

will not be authorized or paid if provider does not have a valid driver's license and automobile insurance.

1. Consumer-employer eligibility

Provider will be paid based on:

- This Agreement,
- The collective bargaining agreement between the Oregon Home Care Commission (OHCC) and Services Employees International Union (SEIU), Local 503, and
- Applicable administrative rules in effect when the approved services were provided to a consumer-employer eligible for publicly funded in-home services.

Provider will be paid for services authorized on a consumer-employer service plan and task list approved by ODHS or an Area Agency on Aging (AAA). Any payment made under any of the conditions below is considered an overpayment:

- Services that are not included on the consumer-employer approved service plan and task list,
- Services provided for more hours than authorized, or
- Services provided to a consumer-employer not eligible for services.

Any overpayments must be repaid to ODHS and are the sole responsibility of the provider.

2. Recordkeeping, access and confidentiality of consumer-employer records

Provider understands and agrees that:

A. Recordkeeping:

- i. Provider is responsible for the completion and accuracy of financial and timekeeping records (for example, timesheets) and all other documentation regarding the specific services for which the provider claims reimbursement. Provider shall keep all records fully documenting the specific services provided to an eligible consumer-employer served under this Agreement for which provider claims reimbursement, in compliance with applicable administrative rules.
- ii. Provider shall keep and be able to provide all records described above in 3(A)(i) for whichever is longer:
 - Six years following final payment and termination of this Agreement
 - Any period as required by applicable law, or
 - Until any audit, controversy or litigation arising from or related to this Agreement is complete.

B. Access:

All financial and timekeeping records and all other documentation related to services provided under this Agreement shall be made immediately available to the following entities and their duly appointed representatives to examine, audit and make copies upon request:

- ODHS
- OHA
- The consumer-employer
- The APD or AAA local office
- The Oregon Department of Justice Medicaid Fraud Unit
- The Oregon Secretary of State Office,
- U.S. Center for Medicare & Medicaid Services, and
- The federal government.

3. Confidentiality

Provider understands provider must keep all information involving provider's consumer-employer confidential. Provider can only share information with the consumer-employer's case manager, the local APD or AAA office or the community health registered nurse working with provider's consumer-employer and as authorized by law.

4. Active enrollment

By signing this Agreement, the provider agrees provider is available and able to provide services to one or more consumer-employers who are eligible for publicly funded in-home services in Oregon. This Agreement and the provider's enrollment will be deactivated if services are not authorized or paid during a twelve-month period. After deactivation, the provider may reapply for enrollment as an HCW if provider wants to provide services to ODHS consumer-employers.

5. Eligibility and continued participation

Eligibility and continued participation as a HCW depend on provider:

- Signing this Agreement
- Completing a new agreement when required
- Meeting all enrollment standards described in OAR 411-031-0040
- Passing a background check, and
- Fulfilling all training requirements outlined in OAR 418-020-0035 (*mandatory training and competency evaluation standards*).

Provider must pass all required provider enrollment database checks prior to enrollment and recertification. This includes, but is not limited to, the Office of Inspector

General (OIG) exclusion list, System Award Management (SAM) exclusion list, Social Security Administration Death Master File, and IRS legal name and Social Security number validation.

6. Provider suspensions and payment recovery

Failure of the application to be accurate in any respect or failure to comply with the terms of this Agreement, APD rules or Oregon Health Authority's rules may result in sanctions, termination of the Agreement or payment recovery per 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 and 410-120-1397 through 410-120-1600. Provider may have appeal rights as described in:

- OAR 411-031-0050 for homecare workers
- OAR 411-034-0055 for personal care attendants, and
- OAR 407-007-0200 through 410-007-0370 when based upon a background check.

7. Employment relationship

- A. The provider understands provider is not employed by the state of Oregon, any division of ODHS or OHA, or by any Area Agency on Aging (AAA) and shall not for any purposes be deemed to be an employee of the state of Oregon (except as set forth in law for purposes of collective bargaining) or an AAA. Any reference to the Home Care Commission as the employer of record is solely for collective bargaining purposes, as provided by state law.
- B. The consumer-employer is responsible to locate, interview and hire a qualified provider. The terms of the employment relationship are the responsibility of the consumer-employer to establish at the time of hire.

8. Medicaid participation

Provider understands and agrees that:

- A. ODHS will verify whether information disclosed by provider is true and accurate. This information will be used to administer the Medicaid program.
- B. Provider will notify ODHS of any changes which would affect this Agreement, or payment for services covered by this Agreement, within thirty (30) days of the change. This includes but is not limited to, changes in name, contact information or criminal records.
- C. Provider shall at all times meet required training and applicable qualifications and be professionally competent to perform work under this Agreement. Failure to complete trainings or meet the applicable qualifications may result in the termination of provider's enrollment.

- D. Any communication or notices from the provider for purposes of this Agreement shall be given in writing to the local Aging and People with Disabilities, Area Agency on Aging (AAA) or ODHS by personal delivery, email, fax or regular mail.
- E. All information submitted by provider in this Agreement is true and accurate. Any deliberate omission, misrepresentation or falsification of any information provided or contained in any communication to ODHS may be punished by administrative or criminal law or both. This includes, but is not limited to, refusal to issue an ODHS provider number, revocation of the ODHS provider number and recovery of any overpayments.
- F. Provider is required to disclose any criminal offense related to the provider's involvement in any program under Medicare, Medicaid or Children's Health Insurance Program since the beginning of those programs.
- G. ODHS will not use public funds to support, in whole or in part, the employment of individuals in any capacity who have been convicted of a crime identified in ORS 443.004(3) and who have contact with Medicaid-eligible individuals.

9. Services

Provider understands and agrees that:

- A. Provider shall perform services identified in the consumer-employer service plan and task list in accordance with the following rules, as applicable:
 - I. OAR chapter 411, division 30 (In-Home Services)
 - II. OAR chapter 411, division 34 (State Plan Personal Care)
 - III. OAR chapter 411, division 35 (K-State Plan Ancillary Services)
 - IV. OAR chapter 411, division 32 (Oregon Project Independence)
- B. Provider shall not enter into any subcontract or authorize another person to perform the services authorized by this Agreement on behalf of provider. Provider understands that by entering into a subcontract or authorizing another person to perform services on provider's behalf is considered Medicaid fraud and is punishable by law.

10. Payment

Provider understands and agrees that:

- A. ODHS shall pay provider on behalf of consumer-employers for HCW services provided under this Agreement that are prior authorized for payment. Payments made by ODHS from public funds are subject to ORS 293.462. ODHS and provider's obligations with respect to ODHS payments to provider are described in OAR chapter 411, divisions 27 and 31; OAR chapter 407, division 120; and OAR chapter 410, division 120.
- B. Provider will be paid at the wage rate agreed upon in the collective bargaining agreement between OHCC and SEIU, 503.

- C. Any payment for services provided to ineligible consumer-employers or for services that were not authorized is the sole responsibility of the provider. ODHS will not make payments on behalf of ineligible consumer-employers or for services that were not authorized.
- D. ODHS payment for any service provided under this Agreement is payment in full. Provider may not charge the consumer-employer, or a relative or representative of the consumer-employer, for:
- Items included in service payments
 - Any items for which ODHS makes payments, or
 - Any additional services provider chooses to provide the consumer-employer.
- By accepting payment, provider certifies compliance with all applicable ODHS rules.
- E. As a condition of payment, provider must meet and maintain compliance with this Agreement and payment rules OAR 407-120-0300 through 407-120-1505, OAR chapter 410, division 120, 42 CFR 455.400 through 455.470, as applicable, and 42 CFR 455.100 through 455.106.
- F. ODHS may recoup any overpayment made to provider as authorized per OAR 410-120-1397 through 410-120-1600 and in accordance with the applicable collective bargaining agreement. This includes, but is not limited to, withholding of future payments to provider.
- G. Payment for HCW services performed beyond the current biennium at the time of signing is contingent on ODHS receiving from the Oregon Legislative Assembly appropriations, limitations, allotments or other expenditure authority sufficient to allow ODHS, in its reasonable administrative discretion, to continue to make payments.
- H. ODHS will not pay provider for work performed:
- Before the agreement is completed and ODHS issues a provider number
 - After the agreement expires or terminates
 - After a background check expires, or
 - While a provider number is deactivated, suspended or immediately terminated.
- I. Provider enrollment and issuance of a provider number does not guarantee work or any minimum amount of work.
- J. 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 they will not be paid.

11. Duration and termination of Agreement

- A. This Agreement is good for 2 years from the date it was signed. The provider must submit a new Agreement at least seventy days prior to expiration for timely processing.
- B. ODHS will terminate, suspend or deactivate this Agreement if:

1. ODHS issues a final order revoking the provider number and enrollment based on a finding under termination terms and conditions established in OAR 411-031-0050.
2. The provider fails to submit timely, complete and accurate information or cooperate with any screening requirements unless ODHS determines it is not in the best interest of the Medicaid program.
3. The provider's enrollment is terminated under Title XIX of the Social Security Act or under a Medicaid program or CHIP program of any state.
4. The provider fails to submit sets of fingerprints in the way determined by ODHS within 30 days of a Centers for Medicare and Medicaid Services (CMS) or an ODHS request, unless ODHS determines it is not in the best interests of the Medicaid program.
5. Provider has been convicted of a criminal offense, or suspended or debarred from provider's involvement with Medicare, Medicaid or the Children's Health Insurance Program in the last 10 years
6. CMS or ODHS determines that the provider has falsified any application information or if CMS or ODHS cannot verify the identity of the provider applicant
7. ODHS fails to receive funding, appropriations, limitations, or other expenditure authority at levels that ODHS or the specific program determines to be sufficient to pay for the services or items covered under this Agreement.
8. Federal or state laws, regulations or guidelines change or ODHS interprets them in a way that prohibits:
 - Providing the services or items under the agreement, or
 - Paying for such services or items from the planned funding source
9. The provider no longer qualifies as a provider. The termination will be effective on the date provider is no longer qualified.
10. The provider fails to meet one or more of the requirements governing participation as an ODHS enrolled provider. This includes the requirement to pass a background check every two years. In addition to termination, suspension or deactivation of the Agreement, the provider number may be immediately suspended, in accordance with OAR 407-120-0360. No services or items shall be provided to consumer-employers during a period of suspension.
11. The provider fails to fulfil all required training and assessment requirements.
12. ODHS may terminate this Agreement at any time with written notification to provider.
13. The provider may terminate this Agreement at any time by submitting a written notice in person or by email to the local office or Area Agency on Aging listing a specific termination effective date. Termination of this Agreement does not relieve the provider of any obligations for covered services or items provided for dates of service while the Agreement was in effect.

12. Provider certifies:

- A. Provider is not in violation of any Oregon Tax Laws. For purposes of this certification, “Oregon Tax Laws” means:
- A state tax imposed by Oregon Revised Statutes (ORS) 320.005 to 320.150 and 403.200 to 403.250, and
 - ORS chapters 118, 314, 316, 317, 318, 321, and 323, and
 - Local taxes administered by the Department of Revenue under ORS 305.620.
- B. Provider is not required to pay backup withholdings because:
- Provider is exempt from backup withholding
 - The Internal Revenue Service (IRS) has not notified provider of being liable for backup withholding due to failing to report all interest or dividends, or
 - The IRS has notified provider of no longer being subject to backup withholding.
- C. Provider will provide services to consumer-employers without regard to race, religion, national origin, sex, age, marital status, sexual orientation or disability (*as defined under the Americans with Disabilities Act*). Contracted services must reasonably accommodate the cultural, language and other special needs of consumer-employers.
- D. Provider is not included on the list titled “Specially Designated Nationals and Blocked Persons.” The U.S. Department of the Treasury Office of Foreign Assets Control keeps this list, available at <https://www.treasury.gov/ofac/downloads/sdnlist.pdf>.
- E. Provider acknowledges that the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any “claim” (as defined by ORS 180.750) the provider makes or causes and that pertains to this Agreement or to the services for which the work related to this Agreement is being performed and payment requested.
- Provider certifies that no claim is or will be a “false claim” (as defined by ORS 180.750) or an act prohibited by ORS 180.755.
 - Provider further acknowledges that in addition to the remedies under this Agreement, if it makes (*or causes to be made*) a false claim or performs (*or causes to be performed*) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties in the Oregon False Claims Act against provider.

13. Indemnification

Provider shall indemnify and defend the state of Oregon, its respective agencies and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever arising out of, or relating to, the acts or omissions of provider under this Agreement.

14. Provider signature

By signing this Homecare Worker Provider Enrollment Application I acknowledge that I have read the enrollment Agreement, understand the terms of the Agreement, agree to be bound by the terms and conditions of the Agreement, and attest that all information I have provided to ODHS is true and accurate. I further understand and agree that violation of any of the terms and conditions in this Agreement are grounds for the 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 date
(effective date)

Return completed document to your local Aging and People with Disabilities office or Area Agency on Aging office.

NOTE: *This form contains your personal information. If you return the form by un-secured email, there is some risk it could be intercepted by someone you did not send it to. If you are not sure how to send a secure email, consider using regular mail or fax.*