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DHS Oregon Department of Human Services
Seniors and People with Disabilities

Medicaid Personal Care Provider Authorization

Applicant information

Last name: _____ First name: _____ MI: _____

Date of birth (mm/dd/yyyy): _____ Medicaid/prime number: _____

Category of service

☐ Developmental Disability Services ☐ Addictions and Mental Health Services

CDDP/AMHD/brokerage name: _____ Branch number: _____

Printed name of service coordinator/case manager/personal agent:

_____ Phone: _____

Email address: _____

Provider information

Last name: _____ First name: _____ MI: _____

Phone number: _____ Date of birth (mm/dd/yyyy): _____

SSN: _____ Mailing address: _____

Provider number: _____ *(for central office use only)*

Provider eligibility verification *(To be eligible, #1, #2 and either #3 a or b or c must apply.)*

☐ 1) Authorized to work in the US *(I-9 Form completed and on file).*

☐ 2) The provider is not a parent or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible person.

3) One of the following must apply:

☐ a. Approved Notice of Final Fitness Determination (DHS form 0300). Form must be signed by an employee of the Criminal Records Unit or an authorized designee. Date of approval: _____.

☐ b. Approved Fitness Determination with restriction; write restriction:

_____

☐ c. Provider on probationary status pending Final Fitness Determination. *(An approved Final Fitness Determination must be obtained within two months of the start date on the Medicaid Personal Care Service Authorization form SDS 0531A.)*

Do ***not*** send a copy of the criminal records check or I-9 to the SPD Provider Payment Unit. This information ***must*** be kept in the provider's file at the local office.

Number hours/month authorized: _____

Stop services: Provider stop date: _____ Reason: _____

If services are stopped before the last day of the month, indicate the number of hours the provider worked in the month. Hours worked: _____

_____ _____

Service coordinator/case manager/personal agent signature Date

Fax to the SPD Provider Payment Unit 503-947-5357