# Agency Direct Support Professional (DSP) User Enrollment Form

* Indicates required fields. **Send completed form to: Info.eXPRS@odhsoha.oregon.gov or fax to 503-947-5044**

**Indicate Action:** ☐ **Add User** ☐ **Change of Information** ☐ **Deactivate User**

| | |
|---|---|
| ***DSP User's Name:** (Last, First, MI) *(Print Name)* | **Social Security Number or eXPRS Login:** |
| ***DSP's Address:** | ***Agency Name:** |
| ***Agency Address:** *(Mailing Address)* | ***Agency eXPRS Provider ID Number:** |
| ***Agency Phone Number:** | ***DSP's Agency Email:** |
| | ***DSP's Personal Email:** |

| Add | Del | User Role/Description |
|---|---|---|
| ☐ | ☐ | **Direct Support Professional** (DSP) – *able to **Create** Service Delivered (SD) billing entries via **eXPRS Mobile-EVV** for assigned Agency provider.* |

☐ I also work as a DSP for other Agency Provider(s) *(please list)*:

***I solemnly swear** (select one):

☐ By checking this box, I acknowledge that **I also work** as a Personal Support Worker.

☐ By checking this box, I acknowledge that **I do NOT work** as a Personal Support Worker.

## *Please Sign Below:

*By signing, I affirm all information provided is true and correct, and acknowledge that failure to accurately represent my role as a Personal Support Worker may be considered Medicaid fraud.*

| | |
|---|---|
| ***Direct Support Professional's Signature:** | ***Date:** |
| **Agency Manager's Name:** | ***Agency Manager's Signature & Date:** |

Maintain a copy of this form in your local file for audit purposes.
Send completed form to: Info.eXPRS@odhsoha.oregon.gov