Agency Direct Support Professional (DSP) User Enrollment Form

* Indicates required fields. **Send completed form to: info.exprs@dhsoha.state.or.us 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@dhsoha.state.or.us