

Agency Direct Support Professional User Enrollment Form

Send completed form to: Info.eXPRS@odhsoha.oregon.gov or fax to 503-947-5044. An asterisk indicates a required field. Maintain a copy of this form for audit purposes.

Select Action	
<input type="checkbox"/> Add User	<input type="checkbox"/> Change of Information
<input type="checkbox"/> Deactivate User	

User Information	
*DSP User's Name: (Last, First MI)	Social Security Number or eXPRS Login:
*DSP's Address:	*Agency Name:
*Agency Address: (<i>Mailing Address</i>)	*Agency eXPRS Provider ID #:
*Agency Phone Number:	*DSP's Agency Email:
	*DSP's Personal Email

Add	Del	User Role/Description
<input type="checkbox"/>	<input type="checkbox"/>	Direct Support Professional (DSP) – able to Create Service Delivered 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.

Signatures Required for All Roles

Direct Support Professional's Signature:

Date:

Agency Manager's Signature:

Date: