Public Partnerships, LLC
Attention: OR FMAS
PO BOX 50040
Phoenix AZ 85076

PCG Public Partnerships
Supporting Choice. Managing Costs.™

DHS
Oregon Department
of Human Services

ID PORF022081

PCG Public Partnerships

Public Focus. Proven Results.™

New Employee Required Forms

Welcome! Public Partnerships LLC (PPL) is excited to serve as your Financial Management Services (FMS) agent. For PPL to assume responsibility for paying you as a provider, you and your employer must complete the program's enrollment process. PPL will help you through each step of the way. The first step is to complete the following Provider enrollment forms:

- ☐ Provider Information and Attestation Form
- ☐ IRS Form W-4
- ☐ Form OR-W-4
- ☐ USCIS Form I-9 (Collected and verified by your Common Law Employer & sent to PPL)

Information and instructions for all new Employee forms can be found at:
www.publicpartnerships.com/programs/oregon/fmas/index.html

PPL will let you know what forms can be checked off ☑ as complete and what forms are missing.

Send your forms to PPL by Fax: 1-844-399-6593 or E-mail* to: PPLORFMAS@pcgus.com.

**PPL does not guarantee the security of emails sent to PPL except those that are sent in response to a PPL secure email.*

To return your forms by mail, send them to:

Public Partnerships, LLC
OR FMAS
P.O. Box 50040
Phoenix, AZ 85076

If you have questions, please call PPL customer service at:
1-888-419-7705
You can also send us an e-mail at PPLORFMAS-CS@pcgus.com.

Si tiene alguna pregunta, por favor llame al servicio al cliente PPL:
1-888-419-7720 – Español
También nos puede enviar un correo electrónico a PPLORFMAS-CS@pcgus.com.

Если у вас есть вопросы, пожалуйста позвоните в PPL обслуживания клиентов по телефону:
1-888-419-7734 - Русский
Вы также можете отправить нам сообщение по электронной почте по адресу PPLORFMAS-CS@pcgus.com

PCG Public Partnerships

Public Focus. Proven Results.™

PROVIDER INFORMATION AND ATTESTATION FORM

In order to complete your enrollment and process your service payments, PCG Public Partnerships, LLC (PPL) must collect all of the information below. Please complete, sign and date this seven (7) page Provider Information and Attestation Form in its entirety and submit it to PPL.

INDIVIDUAL INFORMATION	
Individual's First Name:	**Individual's Last Name:**

PROVIDER INFORMATION		
Provider First Name:	**Provider M.I.:**	**Provider Last Name:**
Providers Maiden/Alias Name(s):		
Date of Birth:	**Social Security Number:**	**Gender:** ☐ Female ☐ Male
Relationship to Member: ☐ Parent / Step Parent ☐ Child ☐ Sibling ☐ Grandparent ☐ Grandchild ☐ Other Relative ☐ Non-Relative		

PHYSICAL ADDRESS		
Physical Address (no P.O. Box):		
Physical Address 2 (apt, bldg., unit, ste., etc):		
City:	**State:**	**Zip Code:**
County:		

MAILING ADDRESS *(if different from Physical Address)*		
Mailing Address:		
Mailing Address 2 (apt, bldg., unit, ste., etc):		
City:	**State:**	**Zip:**

INDIVIDUAL NAME:	PROVIDER NAME:

CONTACT INFORMATION	
Preferred Method of Contact: ☐ Phone Number ☐ Mobile Phone Number ☐ Email Address	
Phone Number:	**Mobile Phone Number:**
PPL has permission to text me using the Mobile Phone Number above (carrier charges may apply): ☐ YES ☐ NO	
Email Address:	

EMERGENCY CONTACT INFORMATION	
Emergency Contact Name:	**Emergency Contact Phone Number:**

INDIVIDUAL NAME:	PROVIDER NAME:

APPLICATION FOR DIFFICULTY OF CARE FEDERAL INCOME TAX EXCLUSION

Certain payments received by an employee for providing Medicaid services in the Employee's home are considered Difficulty of Care payments excludable from federal income tax. To determine if you are eligible for the income exclusion, complete the following steps. If you are eligible, PPL will not report the payments as income and will not withhold federal income taxes.

STEP 1: Review information regarding the Difficulty of Care Federal Income Tax Exclusion. Information is available on PPL's website at: http://www.publicpartnerships.com.

STEP 2: Check all that apply:

☐ **I provide services to the individual participant in my home.** *(Please note that in order to self-direct support services, the individual must live in their own private residence or that of your family member.)*

☐ **I do not have a separate home where I reside.**

☐ **This is the home where I reside and regularly perform the routines of private life, including shared meals and holidays with family.**

STEP 3: If all of the above do not apply, you are not eligible for the Difficulty of Care Federal Income Tax Exclusion.

STEP 4: If all of the above apply, you are eligible for the Difficulty of Care Federal Income Tax Exclusion.

Under penalties of perjury, I declare that I am an individual care provider receiving payments under a state Medicaid Home and Community-Based Services program. I live in the home with, and I provide services to, the individual listed at the top of this form.

IMPORTANT: If you no longer reside with the individual you provide services to, you must notify PPL and terminate your Difficulty of Care Federal Income Tax Exclusion.

INDIVIDUAL NAME:	PROVIDER NAME:

PAYMENT INFORMATION *(If a payment selection is not checked, then PPL will send you your payments by paper check)*
Payment Selection: *(please check only one box)* ☐ Direct Deposit ☐ ADP ALINE™ Payroll Card ☐ Paper Check
DIRECT DEPOSIT:
Account Type: *(please check one box)* ☐ Checking Account ☐ Savings Account

ACCOUNT INFORMATION	
Banking Institution Name	
Routing Number	
Account Number	
Account Nickname (if desired)	

REMITTANCE ADVICE
☐ **I want to stop receiving my paystub in the mail. I will look at my paystub on the BetterOnline™ Web Portal.**

Direct Deposit can be cancelled by calling customer service. If you are changing your bank account information, a new form must be submitted.

INDIVIDUAL NAME:	PROVIDER NAME:

RELATIONSHIP QUESTIONNAIRE
1. Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for the purpose of providing domestic services? ☐ **YES**, that description fits my status. ☐ **NO**, that description does not fit my status.
2. Are you the child of the employer (includes adopted children)? ☐ **YES**, my employer is my parent (mother or father). ☐ **NO**, my employer is not my parent.
3. Are you the spouse of the employer? ☐ **YES**, my employer is my spouse (husband or wife). ☐ **NO**, my employer is not my spouse.
4. Are you the parent of the employer (includes adopted children)? ☐ **YES**, my employer is my child (son or daughter). ☐ **NO**, my employer is not my child.
5. If you answered, "YES," to Question 4, check any of the following that apply. If you answered, "NO," proceed to Question 6. ☐ **YES**, I also provide care for my grandchild or step-grandchild in my child's home. ☐ **YES**, my grandchild or step-grandchild is under 18, or has a physical or mental condition that requires personal care of an adult for at least four continuous weeks during the calendar quarter in which services are performed. ☐ **YES**, my child (son or daughter) is widowed and divorced and not remarried, or living with a spouse who has a mental or physical condition which prohibits the spouse from caring for my grandchild for at least four continuous weeks during the calendar quarter in which services are performed.
6. Are you under the age of 18 or do you turn 18 this calendar year? ☐ **YES**, I am under 18 or am turning 18 this calendar year. ☐ **NO**, I am over 18. *If you answered, "**YES**," to Question 6, answer the following question. If you answered, "**NO**," skip the question below.* **Is this job of performing household services (respite or nursing) your principal occupation? Note: Do not answer, "YES," if you are a student.** ☐ **YES**, this is my principal occupation. ☐ **NO**, this is not my principal occupation.

Mutual Responsibilities

The parties agree to follow the policies and procedures of the OR FMAS. The Provider and Program Participant or Designated Representative agree to hold harmless, release and forever discharge OR ODDS and Public Partnerships, LLC from any claims and/or damages that might arise out of any action or omissions by the employee or Member.

Acknowledgement - I acknowledge the following:

- ✓ I am an Employee of the Individual/Employer, and am not the Employee of PPL or OR ODDS.
- ✓ Information shared with the Employee by the Individual/Employer or the OR FMAS and affiliated agencies regarding the Program Participant shall be confidential.
- ✓ The Individual/Employer shall set the conditions of employment, and termination of employment shall be the prerogative of the Program Participant/Designated Representative.
- ✓ I understand I will be subject to an Employee's background screening through the OR ODDS Safety Registry prior to employment and that that the results of the background screening may be shared with the OR FMAS and/or the Individual/Employer with whom I work.
- ✓ I understand that I am not authorized to begin employment until the results of the background screening have been received and approved, I have completed and returned all required paperwork for credentialing with the state of Oregon and been approved to work, I have completed all trainings, and my Individual/Employer has received an "Good to Go" notification from PPL.
- ✓ I understand that I will be covered by workers' compensation insurance and unemployment insurance.
- ✓ I understand that PPL will pay me on behalf of the Individual on a biweekly basis, following the submission of accurate and approved timesheets and service documentation.
- ✓ I understand that I may not bill Medicaid if (1) the Individual becomes ineligible for Medicaid Services, (2) the Provider performs unauthorized tasks or works more hours than are approved on the Individual's Service Plan, or (3) the Employee begins work prior to receiving notice of "Good-to-Pay" from PPL.
- ✓ I understand I will not be paid for services when the Individual is hospitalized or for any other services not specifically authorized on the Individual's service plan.
- ✓ I understand that must notify PPL if I wish to change my payment and tax withholding preferences. I understand that I must notify the Provider Relations Unit at psw.enrollment@state.or.us if I wish to update my address or personal information.

Attestation

By signing below, I and my Individual/Employer attest that we have read and understand all program rules and responsibilities. I understand I must sign and return this form as a condition of employment in this program. I further attest by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions may result in termination of this agreement.

The Individual/Employer understands that it is their responsibility to properly execute the USCIS Form I-9, as defined in Instructions for Employment Eligibility Verification by the Department of Homeland Security. PPL provides the Form I-9 in the employment packets, and the Individual/Employer retains the original Form I-9 and forwards a completed copy to PPL; which PPL will retain in the Employee's files.

If I request the Direct Deposit payment selection, I authorize PPL to process payments owed to me for services authorized by OR FMAS. PPL will deposit my payment directly into my bank account using Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify that I have read and agree to comply with PPL rules governing payments and electronic transfers. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL.

COMMON LAW EMPLOYER NAME: _____

COMMON LAW EMPLOYER SIGNATURE **DATE:** _____

PROVIDER NAME: _____

PROVIDER SIGNATURE: **DATE:** _____