

PROVIDER ENROLLMENT CHECKLIST

Provider's Name:

➔ YOUR NAME

(Print Last Name, First Name & Middle Initial)

1. Appointment Date:

➔ TODAY'S DATE

2. Are you a County employee/related to a County employee?

Yes

No

3. Did you get fingerprinted for criminal background check with O.C.?

Yes

No

DIFFERENT mailing address reason (if any):

➔ REASON WHY MAILING

ADDRESS IS DIFFERENT FROM YOUR HOME ADDRESS

Email Address:

➔ YOUR EMAIL ADDRESS

Translator (if any):

➔ IF SOMEONE TRANSLATED INFORMATION

(Print First & Last Name)

➤ I understand that all information I gather while serving as a translator for the applicant Provider and on behalf of the Public Authority (PA) is confidential and cannot be shared without the consent of the Provider. I also understand that I must interpret exactly what is being said, not adding to or leaving out any information given by the Provider or PA employee.

➤ I have translated all the information given to ensure the Provider receives complete understanding of the enrollment process and assisted with filling out forms, but the Provider signed them.

➔ TRANSLATOR'S SIGNATURE

Translator's Signature

➔ DATE SIGNED

Date

Provider's Acknowledgment:

I understand that I must complete all the Provider Enrollment requirements within 90-calendar days from the date I attended my appointment. Otherwise, the system will automatically inactivate my status as a Provider and I will need to begin the enrollment process over again. Any missing documents must be submitted in a timely manner to prevent delays in timesheet issuance and payment. I understand that I must submit timesheets regularly to remain in active status. If I do not have payroll activity for over one year, the system will automatically inactivate my status as a Provider.

➔ YOUR SIGNATURE

Provider's Signature

➔ DATE SIGNED

Date

OFFICE USE ONLY

Pending: 426A Start Date Signature No Recipient

Copy of Live Scan Form

Other: _____

PA Staff confirmed checklist information via telephone call w/ Provider on _____

Date

PA Staff initials: _____

PA Staff Reviewer Initials: _____

Date: _____