

PROVIDER ENROLLMENT CHECKLIST

Provider's Name: _____
(Print Last Name, First Name & Middle Initial)

1. Appointment 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): _____

Email Address: _____

Translator (if any): _____
(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 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.

Provider's Signature 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: _____