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 ➡ DATE SIGNED

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.

➡ YOUR SIGNATURE ➡ DATE SIGNED

Provider's Signature Date

OFFICE USE ONLY

Pending: 426A ☐ Start Date ☐ Signature ☐ Copy of Live Scan Form

☐ Other: ______________________ PA Staff initials: ______________

Reviewer Comments: ____

☐ PA Staff confirmed checklist information via telephone call w/ Provider on ______________
Date

PA Staff initials: ______________

PA Staff Reviewer Initials: ______________ Date: __________________

(Updated 6/2023-LN)