

STATEMENT OF AGREEMENT

(do not initial, comment, or mark on form)

I certify that:

- I am not currently revoked or suspended by any state licensing agency;
- My license is current and active. I am not currently excluded, suspended or otherwise barred from participation in Medicare and Medicaid programs or any other federal or federally assisted programs; and, I understand a credentials check will be performed initially and periodically by the Social Security Administration (SSA)/Washington Division of Disability Determination Services (DDDS);
- I do not have a current or pending Federal SSA Contract;
- I have a minimum of five (5) years of current experience with psychological consultation with the DDDS;
- I am able to work a reliable and consistent schedule, and will be available to work within the DDDS system availability hours (Monday – Sunday, 3:00 AM – 11:00 PM PST) and provide consultation and questions during core business hours (Monday – Friday, 6:00 AM – 6:30 PM PST);
- I am to serve as a consultant to the Division Director or designee to ensure psychological reviews are conducted consistently with SSA POMS and current psychological practices;
- I am able to participate in mandatory quarterly MC Meetings during the months of February, May, August, and November (unless excused in advance);
- I am to attend training sessions as required;
- I am to submit properly completed work in the Monthly Time Report form. I am to quantify all completed reviews marked as done in NCPS for each Calendar Month to include in my monthly billing to the DDDS;
- I understand I am expected to maintain an accuracy rate of ninety-one percent (91%) or greater and maintain a standard of quality and timeliness that satisfies all SSA/DDDS requirements and standards in all cases;
- I am not to directly contact medical providers outside my scope of work which includes making recommendations to Adjudicative Staff to contact medical providers to perform consultative examinations, obtaining medical evidence, and corresponding with medical providers to conduct/schedule consultative examinations, etc.;
- I am not to provide comments or references that are unprofessional in case files, emails, letters, or any correspondences;
- I am to treat DDDS staff with courtesy and respect;
- I am not to use social media (e.g. Facebook, Google, Instagram, Twitter, etc.) for gain of DDDS Client information; and understand this applies to using a computer or personal device; and

I certify that, to the best of my knowledge and belief, all the information on this form is correct. I understand that I will not be considered for an agreement to provide services if I am unable to certify to the above and that false certification will be grounds for termination of any resulting agreement to provide services.

Applicant Signature

Date