PACE Provider Certification Application

CHECK APPLICATION TYPE: NEW ☐ OR RENEWAL ☐

STATE OFFICE USE ONLY

Reviewed by: _____ Date: _____

DOCUMENTS: _____ INS _____ LIC _____ BKGR

CERTIFICATION #:

SECTION ONE—Provider Information (Please type or print)

Name of Provider | Employee Identification Number (EIN)

Street and P.O. Box (if applicable)

City | State | Zip Code | County

Mailing Address if different from above

Agency Contact Person | Contact Person E-Mail Address

( ) Telephone Number | ( ) Fax Number

Generic Agency E-Mail Address (**required**) | Website (if applicable)

Email Address: daas.providers@arkansas.gov
Fax Number: 501.682.6245
Mailing Address: DHS/DAAS
ATTN: Certification Unit
PO BOX 1437-Slot S-530
Little Rock, AR 72203-1437

SECTION TWO—PACE Provider Documentation

The Program of All-Inclusive Care for the Elderly (PACE) Organization (mark all that apply)

____ is **licensed as an Adult Day Health Center** by the Arkansas Department of Human Services, Office of LTC.

____ has a **signed three-way agreement** by Division of Aging and Adult Services (DAAS), Centers for Medicare and Medicaid Services (CMS), and the PACE agency provider.

____ has **completed all portions** of this application packet.

____ has completed a recertification, renewal packet **within 30 days prior to expiration**.

Agencies applying/reapplying for certification as a Program of All-Inclusive Care for the Elderly (PACE) provider must attach the following documents to this application:

- A copy of the current **Adult Day Health Care Facility license** issued by the Arkansas Department of Human Services — Office of Long-Term Care.
- Copies of appropriate licensure and/or certifications necessary for staff members positions.
- Attach a spreadsheet of a current list of **criminal background check(s)** for each employee and supervisor. The list should contain the name(s) and date(s) of the last background check(s). Here is an example:

FULL NAME	Have you lived continuously in Arkansas for the last 5 years?	Have you lived in another state within the past 5 years? If so, what state?	Date of Last Background Check
John Lewis Doe	No	List State(s)	01/15/2014
Sarah Jane Doe	Yes	Arkansas	06/08/2012

- A current copy of the agency's **Professional Liability Insurance** including the amount of coverage and expiration date.
- Read, sign, and submit **AAS-9558** Provider Assurances (**see Section Three**) with this application.
- Mark each county in which services will be provided and list zip codes on the **AAS-9560** (**see Section Four**) then submit with this application.

SECTION THREE—Provider Assurances

As written in Section II of the ***Program of All-Inclusive Care for the Elderly (PACE) Medicaid Provider Manual,*** the following text may be found at **https://www.medicaid.state.ar.us/Provider/docs/pace.aspx**

The PACE provider approved to receive Medicaid reimbursement for services must meet specific qualifications. Pace providers must meet the provider participation and enrollment requirements contained within Section 140.000 of the provider manual as well as following criteria to be eligible to participate in the Arkansas Medicaid Program:

The Pace provider must be certified by the Division of Aging and Adult Services (DAAS) as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

The PACE provider must maintain their provider files at the Hewlett Packard Enterprise Provider Enrollment Unit by submitting current certification, licensure, etc., all DAAS-issued certification renewals, and any other renewals affecting their status as a Medicaid-eligible provider.

The PACE provider application must be approved by the Centers for Medicare and Medicaid Services (CMS) and the Division of Aging and Adult Services (DAAS).

Staff members (employees and contractors) of the PACE Organization must be legally authorized, which means currently licensed, certified or register, if applicable, to practice in the state and only act within the scope of his/her authority to practice.

The PACE provider must revalidate enrollment at least every 5 years (see section 1, 141.100).

All medical records of PACE participants must be completed promptly, filed, and retained for a minimum of 6 years (see section 2, 205.000 – 205.300).

I hereby certify that statements are true to the best of my knowledge and belief. I am aware that any willful misrepresentation of any material fact contained in or added as an attachment to this application will result in the denial of certification.

I have read and accept the regulations and provider assurances in the Program of All-Inclusive Care for the Elderly (PACE) Medicaid Manual. Visit the following link and access Section II under Provider Manual:

https://www.medicaid.state.ar.us/Provider/docs/pace.aspx

I further affirm that eligibility for certification is contingent upon the agency's compliance with any federal, state, or local licensure or certification requirements for the provisions of services.

SIGN HERE

Signature of Principal Official_____

Printed or Typed Name of Principal Official_____

Title_____Date_____

SECTION FOUR—Counties Served

The following information is required to process this application. Please check the following box(es) of the county/counties listed below where services will be provided to clients.

- ☐ Arkansas
- ☐ Ashley
- ☐ Baxter
- ☐ Benton
- ☐ Boone
- ☐ Bradley
- ☐ Calhoun
- ☐ Carroll
- ☐ Chicot
- ☐ Clark
- ☐ Clay
- ☐ Cleburne
- ☐ Cleveland
- ☐ Columbia
- ☐ Conway
- ☐ Craighead
- ☐ Crawford
- ☐ Crittenden
- ☐ Cross
- ☐ Dallas
- ☐ Desha
- ☐ Drew
- ☐ Faulkner
- ☐ Franklin
- ☐ Fulton
- ☐ Garland
- ☐ Grant
- ☐ Greene
- ☐ Hempstead
- ☐ Hot Spring
- ☐ Howard
- ☐ Independence
- ☐ Izard
- ☐ Jackson
- ☐ Jefferson
- ☐ Johnson
- ☐ Lafayette
- ☐ Lawrence
- ☐ Lee
- ☐ Lincoln
- ☐ Little River
- ☐ Logan
- ☐ Lonoke
- ☐ Madison
- ☐ Marion
- ☐ Miller
- ☐ Mississippi
- ☐ Monroe
- ☐ Montgomery
- ☐ Nevada
- ☐ Newton
- ☐ Ouachita
- ☐ Perry
- ☐ Phillips
- ☐ Pike
- ☐ Poinsett
- ☐ Polk
- ☐ Pope
- ☐ Prairie
- ☐ Pulaski
- ☐ Randolph
- ☐ Saline
- ☐ Scott
- ☐ Searcy
- ☐ Sebastian
- ☐ Sevier
- ☐ Sharp
- ☐ St. Francis
- ☐ Stone
- ☐ Union
- ☐ Van Buren
- ☐ Washington
- ☐ White
- ☐ Woodruff
- ☐ Yell

List the zip codes for the service areas:

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

IMPORTANT: The effective date of this certification does **NOT** establish Medicaid eligibility for the PACE client and does not guarantee Medicaid payment.