

ARChoices in Homecare Provider Application

STATE OFFICE USE ONLY

Reviewed by: _____

Date: _____

DOCUMENTS: _____ INS _____ LIC _____ BKGR

CERTIFICATION #:

CHECK APPLICATION TYPE: NEW OR RENEWAL

Enter the appropriate Personal Identification Number (PIN)/Employer Identification Number (EIN); mark **service(s)** for renewal or new **service(s)** you are applying; and complete the appropriate section(s) in the remainder of the application for service(s) required. Applications may be submitted by email, fax, or mail to one of the addresses provided on the application. *****More than one service can be selected*****

Provider Name _____

EIN (NEW)	PIN (RENEWAL)	SERVICES	COMPLETE SECTIONS
		<input type="checkbox"/> Attendant Care	1, 2, 8, 9
		<input type="checkbox"/> Adult Day Services	1, 3, 8, 9
		<input type="checkbox"/> Adult Day Health Services	1, 3, 8, 9
		<input type="checkbox"/> Home-Delivered Meals	1, 4, 8, 9
		<input type="checkbox"/> Personal Emergency Response System	1, 5, 8, 9
		<input type="checkbox"/> Respite Care Check One: In-Home <input type="checkbox"/> <u>or</u> Facility-Based <input type="checkbox"/>	1, 6, 8, 9
		<input type="checkbox"/> Targeted Case Management (TCM)	1, 7, 8, 9

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 ONE—Provider Information (Please type or print)

Name of Provider _____ (EIN) _____

Street and P.O. Box (if applicable) _____

City _____ State _____ Zip Code _____ County _____

Agency Contact Person _____ Contact Person E-Mail Address _____

() _____ () _____

Telephone Number _____ Fax Number _____

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

SECTION TWO—Attendant Care Provider

Providers must employ qualified attendant care/ personal care aides. To verify, attach the following documents:

- A copy of **current license or certification**:
 - **Class A Home Health Agency license** issued by the Arkansas Department of Health,
 - **Class B Home Health Agency license** as issued by the Arkansas Department of Health, **OR**
 - **Private Care Agency/Personal Care Agency** license issued by the Arkansas Department of Health
- Create and 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 Eight**.)
- Mark each county services will be provided on the **AAS-9560** (see **Section Nine**) and submit with this application.

SECTION THREE—Adult Day & Adult Day Health Services Provider

The following documents must be attached to the application:

- A copy of the current **Adult Day Care** and/or **Adult Day Health Care Facility license** issued by the Arkansas Department of Human Services – Office of Long-Term Care.
- Create and 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 Eight**) with this application.
- Mark each county services will be provided on the **AAS-9560** (see **Section Nine**) and submit with this application.

SECTION FOUR—Home-Delivered Meals Provider

The following documents must be attached to the application:

- A copy of current **Food Establishment Permit** issued by the Arkansas Department of Health.
- The **name** of your **registered dietician**, _____.
- Create and 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 Eight**.)
- Mark each county services will be provided on the **AAS-9560** (see **Section Nine**) and submit with this application.

SECTION FIVE—Personal Emergency Response System (PERS) Provider

For a NEW provider application, complete parts TWO and THREE.
For a RENEWAL application, complete steps ONE and TWO only.

PART I

Has the toll-free number programmed in the communicator equipment changed since the last renewal period?

No Yes If yes, please list new number _____

PART 2

The following documents must be attached to the application:

- A copy of the current **Underwriters Laboratories Certificate of Compliance** for Protective Signaling Services.
- Create and 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 Eight**.)
- Mark each county services will be provided on the **AAS-9560** (see **Section Nine**) and submit with this application.

PART 3

Please answer the following questions below and on the next page (questions 1-6):

1. What measures are taken to ensure that all PERS staff are aware of and adhere to the agency's written emergency procedures?

SECTION FIVE Continued

SECTION SIX—Respite Provider

In-Home Respite Provider must attach the following documents:

- State Board of Health **Class A and/or Class B License** as providers of personal care and/or home health services.
- Create and 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

- Read, sign, and submit **AAS-9558 Provider Assurances** (see **Section Eight**.)
- Mark each county services will be provided on the **AAS-9560** (see **Section Nine**) and submit with this application.

“Facility-Based” Respite Providers must attach **ONE** of the following documents:

- **Adult Day Care Facility License;**
- **Adult Day Health Care Facility License;**
- **Hospital License;**
- **Residential Care Facility License;**
- **Nursing Facility License;**
- **ARChoices Adult Family Homes Certification;** or
- **Level II Assisted Living Facility License.**

SECTION SEVEN—Targeted Case Management Provider

Please check below, which applies:

___ Licensed as a **Class A Home Health Agency** by the Arkansas Department of Health; attach a copy of the agency’s **Class A Home Health Agency license** for operational period _____.

Please send a copy of this license to DAAS as soon as it is received from the Arkansas Department of Health in January.

___ Licensed as a **Class B Home Health Agency** by the Arkansas Department of Health; attach a copy of the agency’s **Class B Home Health Agency license** for operational _____.

Please send a copy of this license to DAAS as soon as it is received from the Arkansas Department of Health in January.

SECTION SEVEN Continued

SECTION SEVEN—TCM Provider—continued

Other Agency (specify) _____

(Attach a copy of **one** of the following for the period _____:

- The agency’s **Private Care Agency - Medicaid Personal Care license** through the Arkansas Department of Health; **or**
- The agency’s **Adult Day Care license** or **Adult Day Health Care license** through the Division of Medical Services, Office or Long Term Care; **or**
- The agency’s **Articles of Incorporation** from the Arkansas Secretary of State’s Office; **or**
- **Some other form of documentation** that validates this agency as an “Agency.”

If you checked “Other Agency,” please supply the following answers:

1. This agency has performed case management services from _____ to _____. Please indicate to whom the agency has performed case management services.
 2. This agency has worked specifically in the field of aging from _____ to _____.
- Create and 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.
- List of targeted case managers — full name and credentials i.e., RN, LPN, MSW etc.
- Read, sign, and submit **AAS-9558** Provider Assurances (see **Section Eight**.)
- Mark each county services will be provided on the **AAS-9560** (see **Section Nine**) and submit with this application.

SECTION EIGHT—Provider Assurances

As written in Section II of the *ARChoices in Homecare Medicaid Provider Manual*, the following text may be found at <https://www.medicaid.state.ar.us/Provider/docs/archoices.aspx>

A. Agency Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an ARChoices Waiver Person-Centered Service Plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to an ARChoices beneficiary.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
 - a. Description of the purpose and philosophy of the ARChoices Waiver Program;
 - b. Discussion and distribution of the provider agency's written code of ethics;
 - c. Discussion of activities which shall and shall not be performed by the employee;
 - d. Discussion, including instructions, regarding ARChoices Waiver record keeping requirements;
 - e. Discussion of the importance of the PCSP;
 - f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
 - g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality;
 - h. Discussion of the beneficiary's rights regarding HCBS Settings as discussed in 201.000 of the ARChoices in Homecare Medicaid Provider Manual.

B. Code of Ethics

The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver beneficiary a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary; and
9. No breach of the beneficiary's privacy or confidentiality of records.

C. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
 - a. Choice must be identified/included in the person-centered service plan.
 - b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
6. In a provider-owned or controlled residential setting (e.g., Adult Family Homes), in addition to the qualities specified above, the following additional conditions must be met:
 - a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - b. Each individual has privacy in their sleeping or living unit:
 - i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
 - ii. Beneficiaries sharing units have a choice of roommates in that setting.
 - iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - c. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
 - d. Beneficiaries are able to have visitors of their choosing at any time.
 - e. The setting is physically accessible to the individual.

- f. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
- i. Identify a specific and individualized assessed need.
 - ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
 - iii. Document less intrusive methods of meeting the need that have been tried but did not work.
 - iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
 - v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - vii. Include the informed consent of the individual.
 - viii. Include an assurance that interventions and supports will cause no harm to the individual.

I have read and agree to the Provider Assurance Agreement.



Signature of Principal Official _____

Printed or Typed Name of Principal Official _____

Title _____ Date _____

SECTION NINE—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.

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

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