

ARChoices
Adult Family Homes

Instructions
for
Completion
Provider Certification Packet



Division of Aging and Adult Services

ADULT FAMILY HOMES (AFH) CERTIFICATION REQUIREMENTS CHECKLIST

This instruction booklet serves as a handy reference when completing forms and gathering documents required for completion of the certification process. Please note that some sections require one document, and some sections require all items listed.

As you gather the required documents, check the box which corresponds to that document. It is helpful to keep the documents with the provider packet so that all may be submitted as one package.

PROVIDER ASSURANCES - AAS-9514

Thoroughly read Sections 100 through 113 (Pages one through nine).

Then, on Page Nine, complete the following:

- Provider Name:** Enter name of AFH or, if no other name, your first and last name.
- Name of Principal Officer:** Your name.
- Title:** Example: Manager, Owner, etc.
- Signature of Principal Officer:** Sign your name.

The remainder of this page will be completed by DAAS.

APPLICATION FOR CERTIFICATION TO PROVIDE ARCHOICES ADULT FAMILY HOMES – AAS-9520

I. Provider Information

Proof of Age

If your birth certificate is used as proof of age, check this item and **attach copy**.

OR

If your current driver's license is used as proof of age, check this item and **attach copy**.

Property Ownership

If you own outright the property to be used, check this item.

OR

If you own the property but are currently making mortgage payments, check this item and fill in the Name, Address, City, State, and Zip Code of the mortgage company.

OR

If you rent/lease the property, check this item and also check the number of residents your landlord has approved. **Attach copy of your landlord's written permission**

Write month, day and year your current lease expires. Write the owner/agent's (landlord's) name, street address, city, state and zip code.

Insurance

You must have liability insurance to cover the AFH and its residents. If you have a policy in effect, check this item and **attach a copy of your policy.**

If you have not yet purchased a policy, check this item. **IMPORTANT: the certification process cannot be completed until a copy of the liability insurance policy is received.**

II. References

Provide the names, phone numbers, and addresses of three individuals who will serve as references and attest to your character and capabilities. Examples of individuals who would be suitable references are supervisors (past or present), co-workers (past or present), friends, or clergy. You should have a balanced mix of individuals as your references.

Provide the name of your primary substitute caregiver, as well as names, phone numbers and addresses of three references for that individual. Provide this information for all other substitute caregivers. Use a separate sheet of paper if necessary and include with other required documentation.

III. Provider Qualifications

Training/Continuing Education

You and all substitute care givers are required to take at least 12 hours of training each year. See Page 13-14 Administrative Rules and Certification Requirements, Section 208, for a listing of appropriate types of courses and information on continuing education.

Financial Status

In the space provided, describe your method for establishing fees.

You must sign this form in the presence of a Notary Public and he/she must complete the appropriate information.

PERSONAL REFERENCE QUESTIONNAIRE – AAS-9521

A copy of the Personal Reference Questionnaire is included in this packet for your information. Please do not complete nor send to your references. DHS/DAAS will send a form to each of your personal references, as well as to those of your substitute caregivers.

PROVIDER CERTIFICATION INFORMATION – AAS-9560

Box at top of page for State Office use only.

Name of provider:	Your name.
Telephone #:	Your contact number.
Street and PO Box and City, State, Zip Code and County:	The address of the AFH.
Contact Person:	Your name as AFH operator.
Title:	Your position in the AFH. Example: Owner/Operator, Manager, etc.
Telephone #:	Your contact number.
County Served:	Check the county in which home resides.
Signature of Principal Official:	Sign your name.
Printed or Typed Name of Principal Official:	Print your name.
Title:	Your position in the AFH. Example Owner/Operator, Manager, etc.
Date:	Enter month/day/year you complete this form.

ARKANSAS MEDICAID PROVIDER APPLICATION - DMS-652

1. **Date of Application:** Enter date you completed this application form.
2. **Your name:** Last, First, Middle Initial.
or
3. **Group, Organization or Facility Name** Complete this section if your AFH will operate under a different name. (See examples on form.)
4. Circle #1 Sole Proprietorship.
5. Enter your Social Security Number or Employee Identification Number if your business has an EIN assigned by the Internal Revenue Service.
6. Do not complete this section.
7.
 - A. The address of the AFH.
 - B. Alternate street address or PO Box, if applicable.
 - C. City State and Zip Code for the AFH—remember to enter the full nine digit code.
 - D. Telephone number of the AFH.
 - E. Fax Number of the AFH.
8.
 - A. Address to which remittance statements and other information will be sent.
 - B. Check item to indicate format in which you prefer to receive manuals, manual updates, and official notices and enter your e-mail address if applicable.
9. In space at top of list, enter the code which follows the name of the county in which your AFH is located. Example: 60 for Pulaski.
10. The two digit code which applies to the AFH has been entered for you. (E5)
11. Check 4-Other or 5 NA. If 4 is checked, you must complete 12 and 13.
12. Enter certification number if you are currently certified.
13. Indicate month, day and year current certification will expire.
14. Enter date which represents end of your AFH's fiscal year. (Calendar, State Fiscal, etc)
15. No information needed – For Pharmacies only.
16. No information needed – For Pharmacies only.
17. Applies only if you are licensed. Example: CAN **Attach a copy of the license**
18. Date your license expires, if applicable.
19. No information needed – For Clinical Laboratory only.

CONTRACT – DMS-653

Page Two: Enter the AFH name.

Page Three: Provider Name – re-enter information/same as Page Two.

Provider By: Sign your name

Name: Print your name.

Title: Owner/Operator, Mgr, etc.

Date: Date form is completed.

Do not complete Provider Enrollment information – For DHS only

OWNERSHIP AND CONVICTION DISCLOSURE - 675

Page One

Read thoroughly before completing form.

Page Two

Individuals: Complete this section if you are the owner.

Name: Insert your name.

Address: Insert your address, including street address, city, state, and zip code

% of interest: Give the percentage of your interest in the company. If you are the sole owner, your percentage will be 100; if you list other owners, the percentages must be equal to 100.

DOB: Insert your date of birth.

SS#: Write your social security number.

Repeat steps for any other person who has an interest in the AFH.

Corporations: Complete if you have incorporated your business.

Name: Insert the name of the corporation or other legal entities.

Address: Insert the address of the corporation.

% of interest: Insert the percentage of interest in the AFH.

Tax ID#: Insert the company's tax id number.

Note that you must provide a copy of IRS form SS4 and the approval letter

Relatives:

Yes: Check here if any of the persons listed in Section One are related. (Ex: spouse, parent, child, sibling, etc.)

No: Check here if no one in Section One is related or if your name is the only one entered.

Name: Write names of related people listed in Section One if you checked Yes.

Relationship: Give the relationship of the people listed.

Section Four:

Yes: Check if any person or corporation listed in the previous sections owns at least 5% of a company which does business with the Arkansas Medicaid Program.

No: Check if no person or corporation listed in the previous sections owns at least 5% of a company which does business with the Arkansas Medicaid Program.

Name: Insert name of person or business if you checked Yes.

Other Provider: For each name listed, insert name of company conducting business with the Arkansas Medicaid Program.

% of Interest: Insert the percentage of ownership in company which conducts business with the Arkansas Medicaid Program if you checked Yes.

Page Three

Section One: Managing Employees of the AFH

Name: Insert your name.

Address: Insert your address.

DOB: Insert your date of birth.

SS#: Insert your Social Security Number.

Repeat for other people who are or will be managing employees of the AFH.

Section Two: Conviction of a criminal offense related to involvement in any program under Medicaid, Medicare, or Title XX programs in any state

Name: Insert name of person convicted of criminal offense

Offense: List conviction information.

Repeat as appropriate for other individuals who have direct or indirect ownership or is an agent or managing employee of the AFH.

Section Three: Convictions or guilty or no contendere pleas

Name: Insert the name of individual(s) with ownership or controlling interest who has been found guilty or pled guilty or nolo contendere to any of the crimes listed in the introduction to this section.

Offense: List conviction information.

Repeat as appropriate.

Page Four

Name: Print your name.

Title: Print your title.

Signature: Sign your name.

Date: Enter date form completed.

DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS – DMS-689

- 1) Provide the name of any subcontractor with whom the AFH has had more than \$25,000 in business transactions in the last 12 months.
- 2) Provide information on any significant business transaction between the AFH and any wholly owned supplier during the past 5 years.
- 3) Provide information on any significant business transaction between the AFH and any subcontractor during the past 5 years.

Name: Print your name.

Title: Print your title.
Signature: Sign your name.
Date: Insert date you complete this form.

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION – W9

Name: Enter your name or the name of the AFH if tax returns will be filed under the business name.

Business Name: Enter the name of the AFH, if it is different from your name.

Check appropriate box: (Example: Individual/Sole proprietor).

Address: Enter the house number and name of the street where the AFH is located.

City, State, and ZIP Code: Enter name of town, state and zip code where AFH is located

Part I: Insert your social security number or employer identification number if one has been issued by the Internal Revenue Service.

Part II: Sign and enter the date you complete this form.

AUTHORIZATION FOR AUTOMATIC DEPOSIT - EFT FORM

Name of Medicaid Provider: Your name or name of AFH.

Provider ID#: Enter if you have an ID number assigned by DHS.

Taxonomy Code: N/A.

Provider Address: Enter the house number and name of the street where AFH is located.

Telephone Number: Enter your telephone number, including area code.

City, State: Enter the name of the town and state in which the AFH is located.

ZIP Code: Enter the zip code for the address of the AFH.

Type of Authorization: Check boxes for new and for Checking or Savings.

ABA Transit Number: This is found at the bottom left of your check. Example: 0741458310950

Bank Account Number: This number will follow the Transit Number at the bottom on your check. Example: 5654792502

Name of Bank: Enter the name of bank on your voided check.

Bank Address: Enter the Number and Name of Street where bank is located.

City, State: Enter names of the town and state in which bank is located.

Zip code: Enter the zip code for the address where bank is located.

Provider's Original Signature: Sign your name.

REMEMBER TO ATTACH A COPY OF A CHECK ON WHICH YOU HAVE WRITTEN THE WORD VOID.

DISCLOSURE OF SERVICES

This form contains a description of care and services provided by your Adult Family Home in addition to what is required by the Division of Aging and Adult Services. The information contained in it will be shared with prospective clients of your AFH. There is space for Comments at the end of each section. This may be used to provide additional information or explanation.

Provider Information:

Enter the name of the AFH or your name if the home does not have a separate name.

Enter street address, city, state, and zip code where AFH is located.

Enter telephone number available at the AFH.

Check box which indicates your work experience.

Check appropriate box to indicate whether you own or rent the home.

Enter length of time you have lived at this address/home (Example: 5 years).

Check Yes or No to indicate whether you have provided AFH services in the past.

If you check Yes, describe you previous AFH experience.

Transportation Service

Check Yes or No to indicate if you will provide transportation service.

If yes, describe transportation which will be provided.

If no, will you assist in arranging transportation? Check Yes or No as appropriate.

Medication Services

Check Yes or No to indicate if family members are allowed to provide medication services to the AFH.

If Yes, describe conditions under which they may assist.

AFH General Information

Check Yes or No to indicate if client must pay a security/cleaning deposit.

If Yes, indicate amount of deposit.

Check Yes or No to indicate if client may smoke inside the home.

If smoking is not allowed inside the home, check Yes or No to indicate if there are designated outside smoking areas.

Check Yes or No to indicate if you keep firearms in the home.

If firearms are in the home, check Yes or No to indicate if they are kept in a locked cabinet or drawer.

If firearms are not secured in a cabinet or drawer, describe where they are located.

Check Yes or No to indicate if clients may bring firearms into the home.

If clients may bring firearms into the home, describe conditions or rules under which this may occur.

Check Yes or No to indicate if a curfew will be imposed on the client.

If a curfew is imposed, describe rules and conditions related to the curfew.

Describe any household rules related to noise level. Describe

any amenities in the home (See examples on form). Describe

the neighborhood in which the AFH is located.

Client's Bedroom

Check Yes or No to indicate if client will have to share a bedroom.

Note that you must provide a dresser and an individual bed for each occupant.

Provide a description of any other furniture in the bedroom.

Check Yes or No to indicate if a telephone is available in the bedroom.

If not, check Yes or No to indicate if there is an outlet so that a client may arrange for his or her own phone.

Check Yes or No to indicate if a television is available in the bedroom.

If a television is available, check Yes or No to indicate if it is equipped with cable or satellite.

If a television is not available, check Yes or No to indicate if there are cable or satellite connectors in the bedroom so that a client may bring his or her own television.

Client's Bathroom

Check Yes or No to indicate if client has a personal bathroom.

If clients have to share a bathroom, check the appropriate box to indicate with whom the client will share

Other Household Members

Indicate the number of individuals currently living in the house.

Describe the relationship between you as AFH provider and others in the home.

Check Yes or No to indicate if any children live in the home.

If there are children in the home, give the ages of the children.

Other AFH Clients

Check Yes or No to indicate if other AFH clients are currently in the home.

If other clients are currently in the home, indicate how many.

Check Yes or No to indicate if there is space for other clients to move into the home.

Check Yes or No to indicate if you plan on offering services to additional clients in the future.

Client's Family Members and Guests

Check Yes or No to indicate if there are specified visiting times.

If there are specified times for family and friends to visit, describe the visitation process.

Check Yes or No to indicate if visitors must contact you to pre-arrange a visit.

If Yes, describe this process.

Check Yes or No to indicate if clients may have overnight guests.

Check Yes or No to indicate if family members may provide input about services and care provided to the client.

If Yes, describe the type of accepted input.

Substitute Caregivers

Check Yes or No to indicate if you will use substitute caregivers.

If Yes, indicate the number of care givers available to assist.

Also, list specific dates and/or times when substitute caregivers will be utilized.

Provide additional information regarding these caregivers.

Pets

Check Yes or No to indicate if there are currently pets in the AFH.

If Yes, give the number of pets, as well as a description of any animals.

Check Yes or No to indicate if clients may bring pets to the AFH.

If Yes, check Yes or No to indicate if a pet deposit is required. Indicate the amount of the required deposit. Also describe conditions or rules under which a client may bring a pet when moving to the AFH.

Note: All pets must be properly vaccinated and records must be maintained on the premises. Also, proper sanitation must be maintained and pets must be under control at all times.