

# Navigating the Provider Certification Process

If you are applying as a NEW provider, complete steps ONE and TWO.

If you applying for a RENEWAL, complete step ONE only.

## Step ONE:

## New and Renewal Applicants

- Find the new application or the renewal application at:

**[http://www.daas.ar.gov/provider\\_services.html](http://www.daas.ar.gov/provider_services.html)**

- Complete each application and submit the following with each application:
  - A copy of **liability insurance or bond**.
  - A current list of **criminal background check** for each employee and supervisor.
  - A copy of the **in-service training schedule** for the current year.
  - If required, a copy of your agency's license issued by the Arkansas Department of Health (**1-800-462-0599**).
- Send all requested documents by email, fax, or standard US postal mail to the following:
  - **Email Address:** [daas.providers@arkansas.gov](mailto:daas.providers@arkansas.gov)
  - **Fax Number:** **501.682.6245**
  - **Mailing Address:** **DHS/DAAS  
ATTN: Certification Unit  
PO BOX 1437-Slot S-520  
Little Rock, AR 72203-1437**

## Step TWO:

## New Applicants ONLY

- Once you receive a letter from the DAAS Certification Unit with your certificate number, you must download the letter during the Medicaid Application process at:

**<https://www.medicaid.state.ar.us/InternetProviderEnrollment/StartAnApplication.aspx>**

1. Click on the "**Black Arrow**" until the application is completed.
2. For help, contact: **1.800.457.4454 OR 501.376.2211.**
3. Follow prompts for "**NEW PROVIDERS.**"

**TIPS**

- After your Medicaid Application and fees have been submitted, Medicaid will issue a PIN (Provider Identification Number). This PIN allows you to bill for Medicaid Services and be paid.
- The DAAS Certification Unit will mail you a certificate with your PIN and expiration date when all steps have been completed!







**SECTION ONE—Provider Information—*continued***

Check the following box(es) of the Arkansas county/counties listed below where you provide services.

- |                                     |                                       |                                      |
|-------------------------------------|---------------------------------------|--------------------------------------|
| <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"/> Iazard       | <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        |



## SECTION TWO—Application Attachments/Experiences

Please check below, which applies:

\_\_\_ Licensed as a **Class A Home Health Agency by the Arkansas Department of Health** (attach a copy of your agency's Class A Home Health Agency license that your agency will be operating under for the period \_\_\_\_\_.) Since you will not receive this license from the Department of Health until sometime in January, please send a copy as soon as it is received.

\_\_\_ Licensed as a **Class B Home Health Agency by the Arkansas Department of Health** (attach a copy of your agency's Class B Home Health Agency license that your agency will be operating under for the period \_\_\_\_\_.) Since you will not receive this license from the Department of Health until sometime in January, please send a copy as soon as it is received.

\_\_\_ A **Unit of State Government** (specify) \_\_\_\_\_  
(Attach some form of documentation for the period \_\_\_\_\_ documenting that your agency is a "Unit of State Government")

\_\_\_ Other Agency (specify) \_\_\_\_\_  
(Attach a copy of **one** of the following for the period \_\_\_\_\_):

- Your agency's **Private Care Agency - Medicaid Personal Care license** through the Arkansas Department of Health; **or**
- Your agency's **Adult Day Care license** or **Adult Day Health Care license** through the Division of Medical Services, Office or Long Term Care; **or**
- Your agency's **ElderChoices services provider certificate** through the Division of Aging & Adult Services; **or**
- Your Agency's **Articles of Incorporation** from the Arkansas Secretary of State's Office; **or**
- **Some other form of documentation** that your agency is 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 \_\_\_\_\_.

Attach the following documents to the application:

- A current list of a **criminal background check** for each employee and supervisor.
- A list/calendar of **in-service training schedule** for the current year.
- Current proof of the agency's **Professional Medical Liability Insurance/Bonding Insurance**.



**SECTION THREE—Certification & Verification**

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 Targeted Case Management Medicaid Manual. Visit the following link and access Section II under Provider Manual:

<https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/tcm.aspx#manual.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.

Signature of Principal Official \_\_\_\_\_



Printed or Typed Name of Principal Official \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

*Please Attach:  
Only ONE Copy of Each Requested Document*

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Fax Number: 501.682.6245  
Mailing Address: DHS/DAAS  
ATTN: Certification Unit  
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Little Rock, AR 72203-1437