Application for Attendant Care Provider Certification

Attendant Care for a Client of the
ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES
Medicaid Waiver Program

March 2015

The Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program

The Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program allows enrolled clients to receive services at home as opposed to an in-patient care facility. Please refer to the *Alternatives for Adults with Physical Disabilities Waiver Program Medicaid Manual* for regulations. The manual is available at:

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

The offer of employment does not indicate approval as a Medicaid Provider. You are not authorized to begin work as a Medicaid Provider until and unless you are approved.

This office will review your application to ensure you continue to meet the eligibility requirements published in the Medicaid Manual. Your application will then be considered according to the eligibility standards of all Medicaid Providers. The client's home and community-based services nurse/counselor or Counseling and Support Manager (CSM) will alert your employer when a determination on your Attendant Care Provider Application is made.

Please note the following:

- The Client should complete all parts highlighted in blue.
- The Attendant Care Provider should complete all parts highlighted in yellow.

Send all requested documents by email, fax, or standard US postal mail to the following:

- **Email Address:** **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

CLIENT INFORMATION

This form must be completed in full and included with your certification application. If you have a legal guardian or an attorney-in-fact who holds authority to manage your healthcare services and decisions, a copy of the court document/legal instrument that established the authority must be included.

Client Name: _____ **Medicaid #:** _____

Attendant Care Provider Name: _____ **Date:** _____

Choose ONE of the following four options:

Option 1 _____ The client will perform all employer tasks without any assistance (recruiting, hiring, training, supervision, terminating, monitoring my timesheets and approving payment).

SIGN HERE

_____
Client Signature

Option 2 _____ The Decision-Making Partner will perform all employer tasks on behalf of the client.

SIGN HERE

_____
Client Signature

Decision-Making Partner Name: _____

Telephone Number: _____

Email Address: _____

Is the Decision-Making Partner authorized to sign your employee's timesheets?

___ YES ___ NO

SIGN HERE

_____
Decision-Making Partner Signature

(Continued on the following page)

Option 3 _____ The client's spouse will perform all employer tasks (recruiting, hiring, training, supervision, terminating, monitoring my timesheets, and approving payment).

Spouse Name: _____

Telephone Number: _____

Email Address: _____

SIGN HERE

_____
Spouse Signature

Option 4 _____ A legal representative (i.e. legal guardian or attorney-in-fact) performs all employer tasks (recruiting, hiring, training, supervision, terminating, monitoring my timesheets, and approving payment) for the client. Court documents/legal instruments **MUST** be attached if selecting this option.

Legal Representative Name: _____

Authority Source: _____

Telephone Number: _____

Email Address: _____

SIGN HERE

_____
Legal Representative Signature

IF NONE OF THE STATEMENTS ABOVE APPLY:

Please contact the HCBS nurse/counselor or CMS immediately.

The client's eligibility to self-direct must be re-assessed before a Certification/Attendant Care Provider Application can be reviewed.

APPLICATION FOR
AAPD CERTIFICATION / ATTENDANT CARE PROVIDER

_____ _____ _____
Attendant Care Provider Applicant's First Name **MI** **Last Name**

_____
Mailing Address (where you want important documents to be mailed)

_____
City/State/Zip Code

_____
Street Address (where you live)

_____
City/State/Zip Code

_____ _____
Home Phone (Area Code and Number) **Cell Phone** (Area Code and Number)

_____ _____
AAPD Client Name **Medicaid Number**

_____ _____
AAPD Client Home Address **Home Phone Number**

_____, AR _____ _____
City **Zip Code** **Cell Phone Number**

PROVIDER ELIGIBILITY REQUIREMENTS

1. Are you 18 years of age or older? ___ YES ___ NO

a. Date of Birth: _____
mm/dd/year

b. Place of Birth: _____
City/State/County

2. Are you a United States citizen or legal immigrant authorized to work in the U.S?

___ YES ___ NO

3. Have you been convicted of any of the following?

a. Abuse or fraud in any setting ___ YES ___ NO

b. Violations in the care of a dependent population ___ YES ___ NO

c. Conviction of a crime related to a dependent population ___ YES ___ NO

d. Conviction of a violent crime ___ YES ___ NO

If yes, please provide date and offense of each crime committed.

Criminal Offense	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Continued on the following page)

4. **Are you able to follow written instructions and maintain records?**

___ YES ___ NO

If no, identify the person who will assist with written instructions to the applicant.

Assistant Name: _____

Telephone Number: _____

Email Address: _____

SIGN HERE

_____
Assistant Signature

5. **Are you able to do simple math in order to complete billing claim forms?**

___ YES ___ NO

If no, identify the person who will perform this task for the applicant.

Assistant Name: _____

Telephone Number: _____

Email Address: _____

SIGN HERE

_____
Assistant Signature

NOTE: To justify payment of Medicaid funds during audits, written claim forms that reflect the actual time worked must still be prepared, complete with signatures, and maintained, even if claims are submitted electronically.

Do you accept this requirement? ___ YES ___ NO

6. **Are you in adequate physical health to perform the job tasks required?**

___ YES ___ NO

(Continued on the following page)

7. **Do you have any disease that can be transmitted through casual contact?**

___ YES ___ NO

If yes, please provide a brief **description** of disease.

_____

_____

_____

_____

8. **Are you a state employee?** ___ YES ___ NO

____ If yes, attach a written waiver of § 19-11-705, which refers to employee conflict of interest, by the director of the Department of Finance and Administration granting permission to proceed with the transaction to such extent and upon such terms and conditions as may be specified. Such waiver and permission may be granted when the interests of the state so require or when the ethical conflict is insubstantial or remote.

9. **Have you read the regulations published in the AAPD Medicaid Manual?**

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

___ YES ___ NO

10. **Do you accept the regulations in the AAPD Medicaid Manual?**

___YES ___ NO

Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program

Service Agreement between

Client and Attendant Care Provider

Client: _____

Attendant Care Provider: _____

As client or legal representative of a client in the AAPD program, I have chosen to self-direct by hiring the above-mentioned individual as AAPD Attendant Care Provider, and, as such, I am the employer. I understand that, as employer, it is my responsibility to train, manage and terminate, if necessary, this attendant care provider/employee, as well as monitor the employee's claims/timesheets for accuracy and approve payment.

As employer, I will direct the attendant care provider/employee to deliver the types of services as outlined in Medicaid policy and in accordance with the Plan of Care. I also will direct the schedule this attendant care provider/employee will follow.

I understand I must comply with the AAPD Medicaid policies.

This agreement will automatically terminate on the date this employee's Provider Certification expires unless terminated earlier by me.

SIGN HERE

_____ _____

Client/Legal Representative/Spouse/ Decision- Making Partner Signature — Date

SIGN HERE

_____ _____

Attendant Care Provider Signature — Date

Arkansas Department of Human Services
Participant Exclusion Rule
DHS Policy 1088

The term "participant" in this policy means a person seeking to become a party to a contract with DHS to furnish services (i.e. AAPD Attendant Care Medicaid Provider).

1088.1.1 Purpose

DHS shall conduct business only with responsible participants. Participants will be excluded from participation in DHS programs not as penalty, but rather to protect public funds, the integrity of publicly funded programs, and public confidence in those programs. It is also the intent of this policy to prevent excluded participants from substituting others, usually immediate family members, as surrogates to continue the practices that caused DHS to exclude the participant.

1088.2.3 Causes for Exclusion

DHS shall automatically exclude a participant if the participant is the subject of final determination that the participant has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or *nolo contendere*, to any crime related to:

A. Obtaining, attempting to obtain, or performing a public or private contract or subcontract

B. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty

C. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony

D. Federal antitrust statutes

E. The submission of bids or proposals

F. Any physical or sexual abuse or neglect when the offense is a felony

Based on this policy, all AAPD Attendant Care Provider Applicants must understand and acknowledge the following:

Your application will be provided to HP Enterprises, a Medicaid Contractor, to ensure that all qualifications required of a Medicaid Provider of AAPD Attendant Care are met. Your application's review will include a national and state background check to determine if you are placed on the DHS Provider Exclusion List or have a criminal record that contains a conviction. If a positive finding results, it will be reviewed by legal staff within the Medicaid Program Integrity Section, who will advise HP on whether a Medicaid Provider Identification Number (PIN) can be assigned.

You will be made aware of any adverse decision in writing by the Medicaid Program Integrity Section, along with what action to take if you desire to appeal the decision.

Attendant Care Provider Applicant Acknowledgement:

By signing below, you indicate that you have read and understand the provided portions of DHS Policy 1088:

_____

Attendant Care Provider Applicant's Printed Name

SIGN HERE

_____ _____

Attendant Care Provider Applicant's Signature **Date**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Aging
and Adult Services

P.O. Box 1437, Slot S-530 · Little Rock, AR 72203-1437
501-682-2441 · Fax: 501-682-8155 · TDD: 501-682-2443

To: Attendant Care Service Providers

From: Division of Aging and Adult Services

Subj: Central Registry for Adult Abuse

Effective immediately, the attached form must be completed, signed and returned to the Division of Aging and Adult Services with all provider enrollment packets. This form must be completed and signed by all Attendant Care providers in order to receive certification and Medicaid enrollment. No PIN (Provider Identification Number) will be issued unless this form is returned with the enrollment packet.

Once the form is received by the Division of Aging and Adult Services, a check will be made to confirm whether or not you are listed on the Adult Maltreatment Central Registry. This is in accordance with Arkansas Code [ACA 12-12-1716].

If an Attendant Care service provider does appear on the registry, both the attendant and the waiver participant will be notified and a decision will be made regarding the attendant's request for Medicaid participation.

If you have any questions, please contact the Division of Aging and Adult Services at 501-682-2441. This form is not difficult to complete. All questions are self-explanatory and should need no further explanation.

Arkansas Department of Human Services
Authorization for Adult Maltreatment Central Registry
For Consumer- Directed Alternatives Program

Print all information in ink or type information

Full Name _____ **Date of Birth**_____

Maiden and/or Any Names Formerly Used **Social Security Number**_____

_____

_____

Current Address (Street, City, State, ZIP)

_____

List all previous addresses from the past 5 years **Dates (From/To)**

_____ _____

_____ _____

_____ _____

_____ _____

I authorize the Department of Human Services/Adult Protective Services to release information from the Adult Maltreatment Central Registry in accordance with Arkansas Code [ACA 12-12-1716] to:

DHS/DAAS
ATTN: Certification Unit
PO BOX 1437-Slot S-520
Little Rock, AR 72203-1437

ALTERNATIVES

I further certify that the information provided on this from is true and correct.

Signature _____ SIGN HERE **Date** _____

DO NOT WRITE BELOW THIS LINE

The above listed applicant was ___/was not ___ found in the Adult Maltreatment Central Registry.

EMPLOYEE (PROVIDER) TAX INFORMATION

DO NOT SEPARATE OR REMOVE ANY OF THESE FORMS!

WHEN COMPLETING THIS PACKET IT IS IMPORTANT TO –

1. **Print your name, address, Social Security Number and sign and date each form within the packet!**

2. **When completing the Employment Eligibility Verification form (Form I-9) located in the middle of the tax packet -**

   (1) As the "employee or provider" you must complete, sign and date Section 1 only!

   (2) Your employer (the Alternatives client) then completes, signs and dates Section 2 Employer Review and Verification where indicated for Signature of Employer.

   ****If the client is unable to sign their name, then someone other than a provider may sign the client's name for them and then using the blank space at the bottom of the page the person should sign their name and write the date. It is very important that they not sign their name on the same line as the client's!**

3. **You are also required to attach copies of two (2) forms of identification using the enclosed "Lists of Acceptable Documents" as a guideline; no other forms of identification will be accepted!**

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H	

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2015

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ►

SIGN HERE

Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4			
5	Enter the number from line 1 of this worksheet	5			
6	**Subtract** line 5 from line 4			6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here			7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed			8	$
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck			9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-__-____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:
SIGN HERE	

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative Employer
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**For persons under age 18 who are unable to present a document listed above:** 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

AR4EC

STATE OF ARKANSAS

Employee's Withholding Exemption Certificate

Print Full Name _____ Social Security Number _____

Print Home Address _____ City _____ State _____ Zip _____

Employee: File this form with your employer. Otherwise, your employer must withhold state income tax from your wages without exemptions or dependents.

Employer: Keep this certificate with your records.

How to Claim Your Withholding

See instructions below

	Number of Exemptions Claimed
1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED	
a. ☐ You claim yourself. *(Enter one exemption)* 1a	
b. ☐ You claim yourself and your spouse. *(Enter two exemptions)* 1b	
c. ☐ Head of Household, and you claim yourself. *(Enter two exemptions)* 1c	
2. NUMBER OF CHILDREN or DEPENDENTS. *(Enter one exemption per dependent)* 2	
3. TOTAL EXEMPTIONS. *(Add Lines 1a, b, c, and 2)* If no exemptions or dependents are claimed, enter zero..... 3	
4. Additional amount, if any, you want deducted from each paycheck. *(Enter dollar amount)* 4	
5. I qualify for the low income tax rates. *(See below for details)*..... 5 Please check filing status: ☐ Single ☐ Married Filing Jointly ☐ Head of Household	☐ Yes ☐ No

I certify that the number of exemptions and dependents claimed on this certificate does not exceed the number to which I am entitled.

Signature: _____ Date: _____

Instructions

TYPES OF INCOME - This form can be used for withholding on all types of income, including pensions and annuities.

NUMBER OF EXEMPTIONS – *(Husband and/or Wife)* Do not claim more than the correct number of exemptions. However, if you expect to owe more income tax for the year, you may increase your withholding by claiming a smaller number of exemptions and/or dependents, or you may enter into an agreement with your employer to have additional amounts withheld. This is especially important if you have more than one employer, or if both husband and wife are employed.

DEPENDENTS – To qualify as your dependent *(line 2 of form)*, a person must *(a)* receive more than 1/2 of their support from you for the year, *(b)* not be claimed as a dependent by such person's spouse, *(c)* be a citizen or resident of the United States, and *(d)* have your home as their principal residence and be a member of your household for the entire year or be related to you as follows: son, daughter, grandchild, stepson, stepdaughter, son-in-law or daughter-in-law; your father, mother, grandparent, stepfather, stepmother, father-in-law or mother-in-law; your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law or sister-in-law; your uncle, aunt, nephew or niece *(but only if related by blood)*.

CHANGES IN EXEMPTIONS OR DEPENDENTS – You may file a new certificate at any time if the number of exemptions or dependents INCREASES. You must file a new certificate within 10 days if the number of exemptions or dependents previously claimed by you DECREASES for any of the following reasons:

(a) Your spouse for whom you have been claiming an exemption is divorced or legally separated from you, or claims his or her own exemption on a separate certificate, **or**

(b) The support you provide to a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year.

OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, does not affect your withholding until next year, but requires the filing of a new certificate by December 1 of the year in which they occur.

You may claim additional amounts of withholding tax if desired. This will apply most often when you have income other than wages.

You qualify for the low income tax rates if your **total** income from all sources is:

(a) Single	$11,412	to	$15,100
(b) Married Filing Jointly (1 or less dependents)	$19,244	to	$24,000
(c) Married Filing Jointly (2 or more dependents)	$23,160	to	$29,900
(d) Head of Household/Qualifying Widow(er) (1 or less dependents)	$16,224	to	$21,200
(e) Head of Household/Qualifying Widow(er) (2 or more dependents)	$19,339	to	$23,900

For additional information consult your employer or write to:

Arkansas Withholding Tax Section
P. O. Box 8055
Little Rock, Arkansas 72203-8055

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Aging and Adult Services

P.O. Box 1437, Slot S530 · Little Rock, AR 72203-1437
501-682-2441 · Fax: 501-682-8155 · TDD: 501-682-2443

Dear Provider:

Providers are encouraged to utilize ELECTRONIC FUND TRANSFER (EFT). EFT allows your Medicaid payments to be directly deposited into your bank account. You will notice a difference in your cash flow with EFT because it makes your money available sooner than the delivery of paper checks through the U.S. Post Office. Your Medicaid Remittance Advice (RA) will continue to be mailed to the mailing address listed on your enrollment application.

If you have direct deposit already, you can disregard this notice. Your money will be deposited into your account as before.

If you wish to have your Medicaid payment automatically deposited, please complete the Direct Deposit Authorization Agreement and attach a **voided check or letter from your bank reflecting the bank's ABA number and your account number**.

If you choose not to enroll in direct deposit, your checks will be mailed to you. Checks are not available for pick up.

If you have questions concerning this letter, please contact us at (501) 682-2441.

Sincerely,

Alternatives Waiver Program
Division of Aging and Adult Services

PLEASE ATTACH VOIDED CHECK HERE

PALCO, INC.

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

I hereby authorize Palco, Inc. to initiate automatic deposits to my checking/savings account indicated below. I also authorize Palco, Inc. to initiate debit entries to the account indicated below for the purpose of correcting an erroneous credit previously initiated to my account. Any changes to my account must be submitted to Palco, Inc. immediately. I agree I will not hold Palco, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I understand that it is my responsibility to verify the crediting of funds by my financial institution prior to writing checks or initiating debits against my account, and I understand that Palco, Inc. is not responsible for any charges I incur from my financial institution as a result of writing checks against my account before funds have been credited to my account.

Employee Name (*please print*) _____ **Social Security #** _____ **Telephone #** ( )_____

Employer Name _____ **Provider/ Palco ID #** _____

ACCOUNT INFORMATION

Reason for authorization: *(CHECK ONE)* ☐ New Account ☐ Change of Account ☐ Cancellation

What type of account is this? *(CHECK ONE)*

☐ **Checking account……** (Attach a voided check or a letter from the bank. The name on the voided check or letter must match your name. *Temporary checks are unacceptable.*)

☐ **Savings account……** (Attach a letter from the bank. The name on the letter must match your name. Your routing and account numbers must be printed on the letter.)

☐ **Prepaid card…..** (Attach the letter that came with the prepaid card. Your name, routing number, & account number must be printed on the letter.)

Print your routing number & account number below and attach the appropriate documentation. (If you do not know your routing & account numbers, please ask your bank for assistance.) *If you are cancelling a prior agreement, you do not need to attach documentation.*

Routing Number _____ **Account Number** _____

SIGNATURE

I understand that deposit slips and temporary checks are unacceptable forms of enrollment for direct deposit and that I must attach the requisite paperwork for my enrollment to be valid. I understand that it may take up to two (2) business days for funds to be credited to my account. I understand that I will be charged $5.00 if I exceed two (2) Direct Deposit Authorization Agreements within a one-year period. This authorization will remain in full force and effect until Palco, Inc. has received **written** notification from me of its termination in such time and in such manner as to afford Palco, Inc. and all appropriate financial institutions a reasonable opportunity to act on it.

SIGN HERE

Signature _____ **Date *(month/day/year)*** _____

FAX TO:
501-753-2616
(No cover sheet needed)

MAIL TO:
P.O. BOX 13280
MAUMELLE, AR 72113

Questions? Please call: 1-877-753-0999

DIVISION OF MEDICAL SERVICES
MEDICAL ASSISTANCE PROGRAM
PROVIDER APPLICATION

As a condition for entering into or renewing a provider agreement, all applicants must complete this provider application. A true, accurate and complete disclosure of all requested information is required by the Federal and State Regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State Regulations to update the information submitted on the Provider Application.

Whenever changes in this information occur, please submit the change in writing to:

Medicaid Provider Enrollment Unit
HP Enterprise Services
P. O. Box 8105
Little Rock, AR 72203-8105

All dates, except where otherwise specified, should be written in the month/day/year (MMDDYY) format. Please print all information.

DMS-652: Arkansas Medicaid Provider Application (PIN)

(1) Enter the current date

(2) Print your last name, first name, middle initial

(3) Leave this blank

(4) The appropriate code has been checked for you

(5) Enter **YOUR** Social Security number. The name on your Social Security card must match the name that you listed on Line 2. If the names do not match, you must notify the Social Security Office where you live and get your name corrected. DO NOT complete the Federal Employee Identification Number line.

(6) Leave this blank

(7) Enter **YOUR** (the attendant's) street address and **YOUR** telephone number. Do not use the address of the person that you work for, unless you live in the same house.

(8a) Enter the address where you want your check to be mailed. If it is the same as the address in line 7, you can write SAME in this space. If you have a post office box, you may enter the box number here. **Remember, this is the address where your check will be mailed. Please make sure it is correct. You must notify the Alternatives program in writing if this address changes or you will not receive your check.**

(8b) The appropriate blank has been checked. If you have an e-mail address, complete that line.

(9) Enter the County Code of the county for YOUR street address

(10) This information has been completed for you.

(11) This section has been completed for you.

(12) Leave this blank

(13) Leave this blank

(14) Fiscal Year end date will always be 12-31; this information has been completed for you

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____
Specialty Code _____ Computer _____
Provider Type _____ OK to Key _____
Keyed _____
Effective Date _____ Maintenance Checked _____

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

(1) **Date of Application:** Enter the current date in month/day/year format.

____/____/____
MM DD Year

(2) **Last Name, First Name, Middle Initial, and Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

If entering any other name such as an organization, corporation or facility, enter the full name of the entity in item 3. NOTE: Item 2 or 3 must be completed, BUT NOT BOTH.

_____ _____ ____ _____
Last Name First Name M. I. Title

(3) **Group, Organization or Facility Name:** Enter full name of the entity.
Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

_____
Corporation Name

_____
Fictitious Name (Doing Business As)
Must submit documentation that the above fictitious name is registered with the appropriate board within your state, (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

(4) **Application Type:** Circle one of the following codes which coincide with fields 2 or 3:

0 = Individual Practitioner (i.e., physician, dentist, a licensed, registered or certified practitioner)
1 = Sole Proprietorship (This includes individually owned businesses.)
2 = Government Owned
3 = Business Corporation, for profit
4 = Business Corporation, non-profit *** copy of Tax Form 501 (c) (3) must accompany this application**
5 = Private, for profit
6 = Private, non-profit *** copy of Tax Form 501 (c) (3) must accompany this application**
7 = Partnership
8 = Trust
9 = Chain

*** NOTE: IF THE TAX FORM IS NOT ATTACHED THE APPLICATION WILL BE DENIED**

(5) **SSN/FEIN Number:** Enter the Social Security Number of the applicant or the Federal Employer Identification Number of the applicant. **IF ENROLLING AN INDIVIDUAL APPLICANT THIS FIELD MUST REFLECT A SOCIAL SECURITY NUMBER.**

____ _____ _____ - _____ _____ - _____ _____ _____ _____
Social Security Number

NOTE: If an individual has a Federal Employee Identification Number, you will need to complete two (2) applications and two (2) contracts. One (1) as an individual and one (1) as an organization.

____ _____ - _____ _____ _____ _____ _____ _____ _____
Federal Employee Identification Number

(6) **National Provider Identification Number (NPI) and Taxonomy Code:** Enter the National Provider Identification Number and the taxonomy code of the applicant.

_____
National Provider Identification Number

_____
Taxonomy Code

(7) **Place of Service - Street Address**

(A) Enter the applicant's service location address, include suite number if applicable. THIS FIELD IS MANDATORY.

_____

(B) Enter any additional street address. (SHOULD REFLECT POST OFFICE BOX IF UNDELIVERABLE TO A STREET ADDRESS)

_____

(C) City, State, Zip+4 Code - enter the applicant's city, state and zip+4 code. Use the Post Office's two letter abbreviation for State. Enter the complete nine digit zip code.

_____ _____ _____
City State Zip Code+4

(D) Telephone Number - enter the area code and telephone number of the location in which the services are provided.

_____ _____
Area Code Telephone Number

(E) Fax Number – enter the area code and fax number of the location in which the services are provided.

_____ _____
Area Code Fax Number

(8a) **Billing Street Address:** This is the billing address where your Medicaid checks, Remittance Statements (RA) and information will be sent. Use the same format as the place of service address, P. O. Box may be entered in billing address.

_____

_____ _____ _____
City State Zip Code+4

_____ _____
Area Code Telephone Number

_____ _____
Area Code Fax Number

(8b) **Provider Manuals and Updates:** Please review Section I sub-section 101.000; 101.200; 101.300 in your Arkansas Medicaid provider manual regarding provider manuals and updates. Choose the format in which you would like to receive manuals, manual updates, and official notices. The Arkansas Medicaid website (www.medicaid.state.ar.us) is updated weekly and the Arkansas Medicaid Provider Reference CD will be distributed quarterly. Providers selecting "Internet only" or "CD with e-mail notification" will receive e-mails notifying them of applicable manual updates, official notices, and remittance advice (RA) messages available at the website; these choices require an e-mail address and Internet access. Providers selecting "CD with paper supplements" will receive the Arkansas Medicaid Provider Reference CD and applicable manual updates and official notices in the mail; these providers can find RA messages with their RAs or at the Arkansas Medicaid website. Providers selecting "paper" will receive a paper copy of the manual and receive supplementary materials on paper to maintain their manual.

_____ Internet only* _____ CD with e-mail notification*

_____ CD with paper supplements _X_____ Paper

* Selection requires an e-mail address and Internet access.

E-mail address: _____

Please make sure your e-mail address will accept e-mail from hp.com. You may need to instruct your network administrator or e-mail provider to accept e-mails from hp.com. Arkansas Medicaid sends e-mail in bulk, and some e-mail services may block bulk e-mail unless instructed otherwise.

(9) **County:** From the following list of codes, indicate the county that coincides with the place of service. If the services are provided in a bordering or out-of-state location, please use the county codes designated at the end of the code list.

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastian	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75

State	County Code	State	County Code	State	County Code
Louisiana	91	Oklahoma	94	Texas	96
Missouri	92	Tennessee	95	All other states	97
Mississippi	93				

(10) **Provider Category (A-C)**
Enter the two-digit **highlighted** code, from the following list, which identifies the services the applicant will be providing.

A) _____A9_____ B) _____ C) _____

Code	Category Description
A8	Alternatives for Adults with Physical Disabilities (Alternative) - Environmental Adaptations
A9	Alternatives for Adults with Physical Disabilities (Alternative) - Attendant Care Services

(11) **Certification Code:** This code identifies the type of provider the certification number in field 12 defines. If an entry is made in this field (11), an entry **MUST** be made in field 12 and 13 unless the entry is a 5. Please check the appropriate code.

0 = Mental Health [ ]
1 = Home Health [ ]
2 = CRNA [ ]
3 = Nursing Home [ ]
4 = Other [X]
5 = Non-applicable [ ]

(12) **Certification Number:** If applicable, enter the certification number assigned to the applicant by the appropriate certification board/agency.

A CURRENT COPY OF THIS CERTIFICATION MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(13) **End Date:** Enter the expiration date of the applicant's current certification number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(14) **Fiscal Year:** Enter the date of the applicant's fiscal year end. This date is in month/day format.

__12__/ 31__
MM DD

(15) **DEA Number:** If applicable, enter the number assigned to the applicant by the Federal Drug Enforcement Agency. Pharmacies must submit this information to be enrolled.

Required for Pharmacies only
A CURRENT COPY OF THIS CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____

(16) **End Date:** Enter the expiration date of the current DEA Number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(17) **License Number:** If applicable, enter the license number assigned to the applicant by the appropriate state licensure board. If the license issued is a temporary license enter **TEMP**. If the license number is smaller than the fields allowed, leave the last spaces blank.

A CURRENT COPY OF THIS LICENSE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(18) **End Date:** Enter the expiration date of the applicant's current license in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(19) **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA):** If applicable, enter the CLIA number assigned to the applicant. **A copy of the CLIA certificate is required in order to have your laboratory test paid**.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Form **W-9**
(Rev. April 1990)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give this form to the requester. Do NOT send to IRS.

Please print or type

Name (If joint names, list first and circle the name of the person or entity whose number you enter in Part I below. See instructions under "Name" if your name has changed.)

Address (number and street)

City, state, and ZIP code

List account number(s) here (optional)

Part I **Taypayer Identification Number (TIN)**

Enter your taxpayer identification number in the appropriate box. For individuals and sole proprietors, this is your social security number. For other entities, it is your employer identification number. If you do not have a number, see *How to Obtain a TIN*, below.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

OR

Employer Identification number

Part II **For Payees Exempt From Backup Withholding (See Instructions)**

Requester's name and address (optional)

Certification.—Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**

(2) I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions.—You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also see *Signing the Certification* under *Specific Instructions*, on page 2.)

Please Sign Here **Signature ▸** SIGN HERE **Date ▸**

Instructions

(Section references are to the Internal Revenue Code.)

Purpose of Form.—A person who is required to file an information return with IRS must obtain your correct taxpayer identification number (TIN) to report income paid to you, real estate transactions, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an individual retirement arrangement (IRA). Use Form W-9 to furnish your correct TIN to the requester (the person asking you to furnish your TIN), and, when applicable, (1) to certify that the TIN you are furnishing is correct (or that you are waiting for a number to be issued), (2) to certify that you are not subject to backup withholding, and (3) to claim exemption from backup withholding if you are an exempt payee. Furnishing your correct TIN and making the appropriate certifications will prevent certain payments from being subject to the 20% backup withholding.

Note: *If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form.*

How to Obtain a TIN.—If you do not have a TIN, apply for one immediately. To apply, get **Form SS-5**, Application for a Social Security Number Card (for individuals), from your local office of the Social Security Administration, or **Form SS-4**, Application for Employer Identification Number (for businesses and all other entities), from your local Internal Revenue Service office.

To complete Form W-9 if you do not have a TIN, write "Applied For" in the space for the TIN in Part I, sign and date the form, and give it to the requester. Generally, you will then have 60 days to obtain a TIN and furnish it to the requester. If the requester does not receive your TIN within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN to the requester. For reportable interest or dividend payments, the payer must exercise one of the following options concerning backup withholding during this 60-day period. Under option (1), a payer must backup withhold on any withdrawals you make from your account after 7 business days after the requester receives this form back from you. Under option (2), the payer must backup withhold on any reportable interest or dividend payments made to your account, regardless of whether you make any withdrawals. The backup withholding under option (2) must begin no later than 7 business days after the requester receives this form back. Under option (2), the payer is required to refund the amounts withheld if your certified TIN is received within the 60-day period and you were not subject to backup withholding during that period.

Note: *Writing "Applied For" on the form means that you have already applied for a TIN* ***OR*** *that you intend to apply for one in the near future.*

As soon as you receive your TIN, complete another Form W-9, include your TIN, sign and date the form, and give it to the requester.

What Is Backup Withholding?—Persons making certain payments to you are required to withhold and pay to IRS 20% of such payments under certain conditions. This is called "backup withholding." Payments that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee compensation, and certain payments from fishing boat operators, but do not include real estate transactions.

If you give the requester your correct TIN, make the appropriate certifications, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

(1) You do not furnish your TIN to the requester, or

(2) IRS notifies the requester that you furnished an incorrect TIN, or

(3) You are notified by IRS that you are subject to backup withholding because you failed to report all your interest and dividends on your tax return (for reportable interest and dividends only), or

(4) You fail to certify to the requester that you are not subject to backup withholding under (3) above (for reportable interest and dividend accounts opened after 1983 only), or

(5) You fail to certify your TIN. This applies only to reportable interest, dividend broker, or barter exchange accounts opened after 1983, or broker accounts considered inactive in 1983.

Except as explained in (5) above, other reportable payments are subject to backup withholding only if (1) or (2) above applies.

Certain payees and payments are exempt from backup withholding and information reporting. See *Payees and Payments Exempt From Backup Withholding*, below, and *Exempt Payees and Payments* under Specific Instructions, on page 2, if you are an exempt payee.

Payees and Payments Exempt from Backup Withholding.—The following is a list of payees exempt from backup withholding and for which no information reporting is required. For interest and dividends, all listed payees are exempt except item (9). For broker transactions, payees listed (1) through (13) and a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker are exempt. Payments subject to reporting under sections 6041 and 6041A are generally exempt from backup withholding only if made to payees described in items (1) through (7), except that a corporation that provides medical and health care services or bills and collects payments for such services is not exempt from

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit full and accurate requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

Ownership or control interest: a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

Ownership Interest: equity in the capital, stock, or profits of the disclosing entity. To determine the percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported).

Managing employee: a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/ persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)
[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, address and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

Individuals – for each individual listed, provide date of birth and social security number

Name	Address	% of interest	DOB	SS#
		100		

Corporations/Limited Liability Companies/Partnerships/Other legal Entities or Organizations – for each legal entity or organization listed, provide the tax identification number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application.

Name	Address	% of interest	Tax ID #

Not Applicable

Are any of the above mentioned persons related to each other as a spouse, parent, child, or sibling?
Yes_____ No_____ If yes, print name and provide relationship.

Name	Relationship

Not Applicable

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program? Yes_____ No_____ If yes, print name and give other provider name and percentage of interest.

Name	Other Provider	% of Interest

Not Applicable

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

List the name, address, date of birth, and social security number for any person who is a managing employee of the named entity:

Name	Address	DOB	SS#

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs in any state:

Name	Offense

Not Applicable

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, (4) federal antitrust statutes, (5) the submission of bids or proposals, (6) any physical or sexual abuse or neglect when the offense is a felony.

Name	Offense

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name:_____ Title:_____
(Print or Type) (Print or Type)

Signature:_____ SIGN HERE Date:_____

Disclosure of Significant Business Transactions
DHS Division of Medical Services, Title XIX (Medicaid)
[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full, complete and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application for new enrollments, or attached to the form for updated information from existing providers, before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS

Submit full, accurate and complete disclosure concerning the following information:

1) Ownership of any subcontractor with whom the named entity has had business transactions totaling more than $25,000 during the last 12 months (12 month period ending as of the date on this application).

Not Applicable

2) Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5 year period ending as of the date of this application).

Not Applicable

3) Any significant business transaction between the named entity and any subcontractor in the last 5 years (5 year period ending as of the date of this application).

Not Applicable

Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name:_____ Title:__Provider_____
(Print or Type) (Print or Type)

Signature:_____ SIGN HERE Date:_____

CONTRACT

TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM ADMINISTERED BY THE DIVISION OF MEDICAL SERVICES UNDER TITLE XIX (MEDICAID)

INSTRUCTIONS

Please ensure that the provider name on the front page of the contract is identical to that listed in item #2 or item #3 of the application.

If these two names do not match, your enrollment will be denied and the enrollment packet will be returned.

CONTRACT
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM
ADMINISTERED BY THE DIVISION OF MEDICAL SERVICES
TITLE XIX (MEDICAID)

The following agreement is entered into between _____, hereinafter called Provider, and the Arkansas Department of Human Services, hereafter called Department:

1. Provider, in consideration of the covenants therein, agrees:

A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services

B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to records. For all Medicaid beneficiaries, these records include, but are not limited to those records which are defined in Section "A" of this contract. For clients who are not Medicaid beneficiaries, the records that must be furnished are financial records of charges billed to non-Medicaid insurance to ensure that charges billed to Medicaid do not exceed charges billed to non-Medicaid insurance.

1) In connection with this contract each party hereto will receive certain confidential information relating to the other party. For purposes of this contract, any information furnished or made available to one party relating to the financial condition, results of operation, business, customers, properties, assets, liabilities or information relating to the financial condition relating to beneficiaries and providers, including but not limited to protected health information as defined by the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is collectively referred to as “Confidential Information."

2) The contract shall safeguard the use and disclosure of information concerning applicants for or beneficiaries of Title XIX services in accordance with 42 CFR Part 431, Subpart F, and shall comply with 45 CFR Parts 160 and 164 and shall restrict access to and disclosure of such information in compliance with federal and state laws and regulations.“

C. To accept assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Title XIX (Medicaid).

D. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, or Remittance Advice message.

E. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the beneficiary or accept any additional payment from the beneficiary except cost share (co-pay or deductible amounts) established by the Medicaid Program.

F. To take assignment and file claims with third party sources (medical or liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party source discovered after submission of a claim or claims to Medicaid.

G. To make no charge to a beneficiary for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of a peer reviewer; except that such charge may be made to the beneficiary when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined "not medically necessary."

H. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

I. To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.

J. That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

K. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

L. To certify by original signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this certification as a matter of record for all claims submitted electronically, by any media.

M. To notify the Department before any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered before the change in ownership or operating status.

N. FOR HOSPITALS ONLY

To understand that the Quality Improvement Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospitals, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

A. To make payment to the above named Provider for the appropriate Medicaid covered services provided to eligible Medicaid beneficiaries in accordance with the applicable Medicaid reimbursement schedule in effect for the dates of service, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.

B. To notify the above named Provider of applicable changes in Medicaid rules and regulations as they occur.

C. To safeguard the confidentiality of any medical records received by the Department or its fiscal intermediary, as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party without cause and/or convenience of either party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:
1) Returned mail
2) Death of provider
3) Change of ownership
4) Or other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

Provider Name: _____
(As inscribed on previous page of contract)

Provider	**Provider Enrollment**
By: _____ SIGN HERE (Signature Required)	By: _____ (Signature)
Name: _____ (Typed or Printed Name Required)	Name: _____ (Typed Name)
Title: __Provider_____ (Required)	Title: _____
Date: _____ (Required)	Date: _____
	Effective Date of Contract: _____