ElderChoices

Personal Emergency Response System (PERS)

Provider Application

Packet Revised 11/09

PERSONAL EMERGENCY RESPONSE SYSTEM
(PERS)

DEFINITIONS

Personal Emergency Response System (PERS): a 24-hour, seven-day-a-week, in-home electronic support system that provides two-way verbal and electronic communication with an emergency control center. It enables an elderly, infirm or homebound individual to secure immediate help in the event of physical, emotional or environmental emergency.

Provider: operator of PERS providing services to elderly (age 65 and older)

Help Device: a devise, worn or carried by the client, which can be pressed to call for help. It signals a central switchboard where a trained staff immediately initiates emergency procedures to respond to the call.

Communicator: the in-home two-way communication equipment attached to the telephone line which receives the wireless signal from the help device and transmits it to the emergency control center.

PROCEDURAL REQUIREMENTS

- PERS provided minimum requirements are to:
- provide service which meets the definition of PERS as set forth above. PERS must be activated by voice, button or other simple device that can be worn or attached to the person;
- designate or operate an emergency response center (monitoring station) where signals are received and response is made according to a specified operating protocol;
- demonstrate fast emergency response capability, i.e., within one or two minutes;
- provide a capability of responding to client's signal even when the client is unable to communicate verbally;
- provide, install and maintain FCC-approved equipment that meets all Underwriter Laboratories safety standards;
- provide emergency power failure backup and safety systems
- establish a specific protocol for answering emergency signals;
- instruct clients in the proper use of the equipment;
- establish response system for each client and ensure that responders receive necessary instruction or training;
- call each client at least once a month to test system operation; the client shall call the medical control center at least once a month to test system operation and as often as necessary to ensure client's familiarity with procedures to use in an emergency. Provider shall maintain a log of monthly client calls;
- provide operational and technical manuals and training to appropriate PERS staff.

EQUIPMENT SPECIFICATIONS

1. Home Units:
    - The home equipment shall be activated by voice, button or other simple device that can be worn or attached to the client.
    - The system shall be useable by persons who are visually impaired, physically handicapped or disabled.
    - The Communicator, the two-way communication equipment, shall have a receiver to receive wireless signals.
    - The Communicator shall be attached to telephone lines and shall not interfere with normal use of the telephone.
    - The Communicator shall have a battery to provide a minimum of six to eight hours of operation in the event of a power failure. It shall also utilize a self-charging system and report its condition to the monitoring station after two hours of power loss.
    - The Communicator shall be equipped with a self-diagnostic program, which it performs in each 24-hour period.
    - The PERS provider shall obtain from the vendor o the equipment detailed manuals relating to the operation of the system, including technical specifications, installation and testing.

2. Monitoring Equipment:
    - The emergency response center equipment shall consist of a primary receiver, a back-up receiver, a clock printer, a back-up power supply and a telephone line monitor.
    - The primary and back-up receivers shall be independent and interchangeable.
    - The printer shall print out the time and date of the emergency signal, the client identification code, and emergency codes indicating active or passive alarm or responder reset.
    - The emergency response center shall have the back-up power supply capacity to operate in excess of six hours.
    - The telephone line monitor shall give visible and audible signals in the event an incoming telephone line is disconnected for more than ten seconds.
    - The emergency response center shall obtain from the equipment vendor detailed manuals relating to the operation of the system, including physical arrangement of the equipment, installation of all elements, testing procedures, emergency reporting and response procedure and servicing.
    - The receiving and printing stations at the monitoring center shall have a minimum of two incoming telephone lines that are automatically interchanged in the event of telephone or equipment malfunction or unusual load demands.

EMERGENCY PROCEDURES

The PERS staff shall have written procedures for dealing with emergencies of clients. The procedures shall cover immediate care of the client, ambulance to be called, name(s) and phone numbers of physician(s), persons to be notified and reports to be prepared.

All PERS staff who provide direct services shall have initial and ongoing training in emergency procedures. These procedures shall include the name and telephone number of the client's attending physician, the client's preference of hospital, name of family members and/or others to be contacted in case of emergency, a listing of any known drug allergies, and any other pertinent medical information which is deemed critical to the care of the client in an emergency.

STAFFING

Duties of all PERS staff must be clearly defined in written job descriptions.

Initial on-location training must be provided to response center staff before they assume normal job responsibilities. This shall include training on all operational aspects of the PERS, including installation and testing of equipment and program implementation.

In-service training for PERS staff must be regularly scheduled. It shall total six hours per year and shall be documented in staff personnel records as to content, date and duration.

DOCUMENTATION

Both provider and emergency response center must maintain technical and operations manuals describing equipment functioning, testing and installation procedures; emergency response protocol; record keeping and reporting procedures; and user agreements.

A log of all client calls will be kept by the emergency response center. The log shall record for each the date, time and nature of the call and the response initiated by the center.

All calls shall be documented in the client's permanent file.

All client records and logs of calls shall be retained in accordance with the requirements of the program under which the service is being funded.

CONFIDENTIALITY

The PERS provider shall have written procedures governing the use and removal of client records and conditions for release of information on individual clients in compliance with state and federal requirements.

Information contained in records maintained by a provider on individual clients shall not be disclosed to any person other than authorized representatives of the Department of Human Services without the express prior written consent of the client.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
ELDERCHOICES PROGRAM

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)
PROVIDER CERTIFICATION

STATE OFFICE USE

SECTION ONE – PROVIDER INFORMATION (Please type or print.)

Name of Provider Agency | EIN Number

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

City | State | Zip Code | County

Agency Contact Person

Telephone Number | Fax Number

E-Mail Address | Website

List the counties where the agency delivers PERS services:

_____

_____

_____

SECTION TWO – PERSONAL EMERGENCY RESPONSE SYSTEM PROVIDER QUESTIONS

1. Please provide the toll-free telephone number(s) programmed in the communicator equipment: _____

_____

Have any numbers changed since the last renewal period? Yes ☐ No ☐

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

3. How does the equipment accommodate clients who are visually and/or physically impaired?

4. What procedures have the agency implemented to ensure the client's familiarity with the system's operation?

5. Please describe the agency's procedures for monthly testing of the system's operation.

6. What documentation does the agency maintain to support fulfillment of these requirements? Where is this information maintained?

7. Does the agency designate emergency response center responsibilities to an outside contractor? If so, describe the safeguards the agency has in place to ensure all provider certification requirements are met by the contractor.

SECTION THREE – APPLICATION ATTACHMENTS

The following must be attached to the application:

1. Copy of the current Underwriters Laboratories Certificate of Compliance for Protective Signaling Services
2. The agency's written job descriptions for staff performing PERS services
3. A list containing the names of all direct care staff and the date of the last criminal background check
4. Current proof of the agency's Professional Medical Liability Insurance/Bonding Insurance
5. A list of in-service training sessions to be held during this certification period. PERS staff must attend a minimum of six hours of in-service training per year.
6. Attach a brief description of the agency's emergency response center operating protocol, if the agency operates an emergency response center.

SECTION FOUR – 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 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_____

The Principal Officer of the agency must sign the attached Provider Assurances.

PROVIDER ASSURANCES
Between
Arkansas Department of Human Services, Division of Aging and Adult Services
And
ElderChoices Home and Community-Based Waiver Provider

The following assurances are applicable to funds administered by the Arkansas Department of Human Services (DHS), Division of Aging and Adult Services, hereafter referred to as the Division, in accordance with policies developed by the Division and the Arkansas Division of Medical Services for the ElderChoices Home & Community-Based 2176 Waiver Program, hereafter referred to as ElderChoices.

The principal official of the agency applying for certification as a provider of ElderChoices services must sign these provider assurances.

The effective period of the assurances will correspond with the Provider certification, but will not exceed a twelve (12) month period. The Provider will be held accountable for further assurances or conditions to the contract that the Division may add, as is deemed necessary.

100 General Assurances

The Provider acknowledges the primary purpose of the ElderChoices Program is to provide alternatives to institutionalization through home and community-based services for persons 65 years of age or older who meet specific medical and financial criteria.

The Provider assures the Division it is in compliance with all existing rules and regulations governing the service(s) being provided and that where state or local jurisdictions require licensure for the provision of the service(s), the agency shall hold a current license.

The Provider assures the Division it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of ElderChoices service(s). The Provider further agrees that in the performance of this agreement, no persons having such interest shall be employed.

The Provider assures the Division all facilities covered by Section 1616(e) of the Social Security Act in which home and community-based services will be provided, are in compliance with applicable State standards and that where applicable meet the requirements of 45 CFR Part 1397 for board and care facilities.

The Provider assures the Division it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and the regulations issued pursuant thereto. Further, the Provider assures it has no commitments or obligation which are inconsistent with compliance with these or other pertinent federal regulations or policies, and that any other agency, organization or party that participates in the implementation of services pursuant to this agreement shall have no such commitments or obligations.

The Provider assures the Division it has written personnel policies in compliance with applicable Federal and State laws and maintains documentation to support that these policies have been communicated to all staff.

The Provider acknowledges DHS is not responsible for any modification, construction, purchasing of equipment or supplies required for compliance with any established rules or regulations the agency must undergo in order to provide ElderChoices services.

The Provider assures the Division it has the authority and capacity to implement and perform the program of services for which they are requesting certification.

The Provider shall not assign any interest in this agreement, and shall not transfer any interest in the same, whether by assignment or notation.

101 Safety and Protection of Clients

Provider for these purposes includes any employee or contracted personnel of the Provider.

The Provider assures the Division it shall not solicit or coerce ElderChoices applicants or clients. Solicitation includes, but is not limited to, verbal or written promotion of the ElderChoices Program made in an effort to persuade an individual or his/her caregiver to apply for services. In the event the Provider is found to have solicited an individual, the Provider shall be required to submit a plan of correction and be prohibited from serving the individual. Failure to correct the solicitation practice may result in the Provider's certification being placed on probation and/or revoked. Coercion is defined as, but not limited to, any verbal or written action which serves to pressure or intimidate an ElderChoices applicant or client for <u>any purpose</u>. In the event the Provider is found to have coerced an ElderChoices applicant or client, the Provider’s certification shall be placed on probation and/or revoked.

The Provider assures the Division all necessary safeguards and precautions have been taken to protect the health and welfare of the clients they serve.

- An ElderChoices provider shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense.
- Each ElderChoices provider must obtain from each employee and from each applicant for employment a signed authorization permitting disclosure to the ElderChoices provider of criminal history information as defined in Ark. Code Ann. Section 12-12-1001.
- Each provider receiving payment under the ElderChoices program must, as a condition of continued participation in the ElderChoices program, comply with this rule requiring criminal history checks for new employees, and requiring periodic criminal history checks for all employees. This requirement applies to any employee who in the course of employment may have direct contact with an ElderChoices recipient. (This does not include volunteers delivering Home Delivered Meals.)
- Before making a temporary or permanent offer of employment, an ElderChoices provider shall inform applicants and employees that continued employment is contingent upon the results of periodic criminal records checks and that the applicant or employee has the right to obtain a copy of the report from the Identification Bureau of the Department of Arkansas State Police ("Bureau").

- When a person applies for a position as an employee of an ElderChoices provider and if the ElderChoices provider intends to make an offer of employment to the applicant, the applicant shall complete a criminal history check form furnished by the ElderChoices provider and shall submit the form to the ElderChoices provider as part of the application process. If the ElderChoices provider intends to make an offer of employment to the applicant, the ElderChoices provider shall, within five (5) days of such decision, forward the criminal history check form to the Bureau accompanied by appropriate payment and request the Bureau to review the Bureau's index of criminal history checks on persons caring for the elderly or individuals with disabilities. An ElderChoices provider may make an offer of temporary employment to an applicant pending receipt of notification from the Bureau.
- If the results of the criminal history check establish that the applicant was found guilty of, or pled nolo contendere (no contest) to, a disqualifying offense under Ark. Code Ann. Section 20-33-205 ("disqualifying offense"), then the ElderChoices provider may not employ, or continue to employ, the applicant. Disqualifying offenses do not include misdemeanors that did not involve exploitation of an adult, abuse of a person, neglect of a person, theft, or sexual contact.

The Provider agrees to operate and provide services in full compliance with all applicable federal, state and local standards including, but not limited to, fire, health, safety and sanitation standards prescribed by law or regulations.

The Provider agrees to comply with all state and federal regulations pertaining to the funding and delivery of the waiver services that the Provider is enrolling.

The Provider agrees to protect the human rights of an ElderChoices client by providing services without regard to race, color, religion, sex or national origin.

The Provider agrees to provide services in an environment free from physical or mental abuse for its clients and employees.

The Provider assures the Division that conditions or circumstances which place an ElderChoices client, or the household of an ElderChoices client, in imminent danger will be brought to the attention of appropriate officials for follow-up.

The Provider acknowledges their responsibility for reporting abuse established by Arkansas Statute 5-28-1 01 et. seq. (Abuse of Adults) as follows:

> Whenever any physician, surgeon, coroner, dentist, osteopath, resident, intern, registered nurse, hospital personnel who are engaged in the administration, examination, care or treatment of persons, social worker, case manager, case worker, mental health professional, peace officer, law enforcement officer, facility administrator, employee in a facility, or employee of the Department of Human Services has reasonable cause to suspect that a resident has been subjected to conditions or circumstances which would reasonably result in abuse, he shall immediately notify the person in charge of the institution, facility, or agency or his designated agent, who shall then become responsible for making a report or cause a report to be made.

In addition to those persons and officials required to report suspected adult abuse, sexual abuse, or neglect, any other person may make a report if the person has reasonable cause to suspect that an adult has been abused or neglected.

A report of abuse, neglect or exploitation of an endangered adult residing in a privately owned or rented home in the community shall be made to Arkansas Adult Protective Services (APS). The APS toll free telephone number is (800) 482-8049 or (501) 682-8491.

102 Staffing

The Provider assures the Division it will employ staff, qualified by education and/or experience, to perform ElderChoices services. Personnel records shall be maintained on all employees as a contingency of certification.

The Provider assures the Division that personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements.

The Provider assures the Division that each service worker, prior to providing any waiver services, has received instructions regarding the general needs of the elderly with regard to the waiver services that the Provider is enrolling. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by the Division. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through the Division or DHS.

The Provider assures the Division that each service worker possesses the necessary skills to perform the specific services required to meet the needs of the client he/she is to serve.

The Provider assures the Division that all service workers are bonded to protect the client from loss due to misconduct or mismanagement of the client’s affairs and are covered under liability insurance.

The Provider assures the Division it will maintain adequate staffing levels to ensure timely and consistent delivery of services to all clients for whom they have accepted an ElderChoices Plan of Care.

Emergency backup plans must be in place and utilized any time usual care is unavailable and the lack of immediate care would pose a serious threat to the health and welfare of the client. The Provider assures the Division it will leave emergency information in each participant's home. The Provider also assures the Division it will contact the client and the emergency contact person any time routine care is unavailable and/or an emergency backup plan is necessary.

103 Service Delivery

The Provider agrees to render all services in accordance with the Arkansas Medicaid ElderChoices Home & Community-Based Waiver Provider Manual.

The Provider agrees to comply with all policies, procedures and guidelines established by the Division.

The Provider agrees to hold the Division and the ElderChoices client harmless and shall indemnify the Division and the ElderChoices clients for any additional costs of alternatively accomplishing the goals of the ElderChoices Program. The Provider accepts liability for costs or fees, not limited to theft or negligence, which the Division or the ElderChoices client may sustain as a result of the provider's performance or lack of performance. This hold harmless clause supersedes any release of responsibility signed by an ElderChoices client. Provider, for these purposes, includes any employee or contracted person providing ElderChoices services under this agreement.

The Provider acknowledges they may render and pursue reimbursement for services delivered in accordance with the Plan of Care developed by the DHS Registered Nurse and signed by the client's attending physician, if required. The Provider acknowledges the DHS Registered Nurse is the only authorized individual who may adjust an ElderChoices client's Plan of Care.

The Provider agrees to visit each client’s home at least once every 90 days to evaluate client satisfaction and service worker performance.

The Provider agrees to inform the DHS Registered Nurse immediately via the AAS-9511of any change in the client's physical, mental or environmental needs the Provider observes or is made aware of that may affect the client's eligibility or would necessitate a change in the client's Plan of Care.

The Provider agrees to review the weekly time sheets of each service worker and to ensure that time sheets are accurate and have been signed by the client or other responsible party.

The Provider agrees to notify the DHS Registered Nurse in writing within one (1) week of services being terminated documenting the termination effective date and the reason(s) for termination.

104 Confidentiality

The Provider agrees to implement procedures to safeguard confidential information regarding ElderChoices clients. The Provider assures the Division no information about or obtained from a client shall be disclosed in any form identifiable with the client without the informed consent of the client.

The Provider assures that lists of ElderChoices clients compiled pursuant to operations under this agreement shall be used solely for the purpose of providing services, will be compiled with the informed consent of each individual on such list and under no circumstances will be made available to any individual or organization other than the Centers for Medicare & Medicaid Services, DHS, Administration on Aging or their respective designees.

105 Record Keeping

The Provider agrees to maintain individual records for each client and to ensure that each record shall include:

1. A schedule of service delivery;

2. Weekly time sheets recording delivery of services and signed by client or responsible party;
3. Record of supervisory visits to the client's home.

The Provider agrees to maintain records in accordance with standard accounting procedures and to comply with all applicable state and federal regulations.

The Provider acknowledges it must maintain all records regarding the client and the Providers participation in the Arkansas Medicaid ElderChoices Program for a period of six years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. All records must be available to authorized representatives, agents or officials of the Division, DHS, Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and the Department of Human Services.

In addition to the documentation requirements imposed on providers as a contingency of Medicaid enrollment, the Provider agrees to maintain and make available for review visit reports, employee time records and incident reports.

106 Fiscal Assurances

The Provider acknowledges that Medicaid payment received for delivered ElderChoices services is payment in full and assures the Division it will apply no additional charges nor accept any additional payment, including donations, from an ElderChoices client or their caregiver for those services.

The Provider agrees to submit program and financial reports to DHS and/or the Division, as required.

107 Grievance

The Provider agrees to develop and implement a written grievance procedure that complies with federal and state regulations that includes, but is not to be limited to, the following:

- A mechanism to inform clients, caregivers and employees of their right to file a complaint regarding service delivery or the Provider's employment practices with the Provider directly, the DHS Registered Nurse, the Division, the Arkansas Medicaid Program or DHS,
- An assurance that the client and/or caregiver may file a grievance or otherwise seek resolution of a complaint or concern without reprisal or disruption of service,
- A provision which allows the client and/or caregiver to file and discuss their concern with the agency administrator and/or supervisory staff, and
- An assurance that every client and/or caregiver's concern will be treated with dignity and respect.

108 Quality Controls

The Provider accepts full responsibility for the quality and number of units of services provided to an ElderChoices client by their personnel and assures the Division appropriate management and supervision of services takes place at all times.

The Provider agrees to continually monitor client satisfaction and quality of service delivery and to record their findings every ninety days on the ElderChoices Quarterly Service Report (AAS-9506) per program policy.

The Provider assures the Division it will provide a drug-free workplace and establish a drug awareness program to inform employees of:

- the dangers of drug abuse in the workplace;
- the Provider's policy for maintaining a drug-free workplace;
- any available drug counseling, rehabilitation, and employee assistance programs; and
- the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

The Provider agrees to require staff to attend orientation training prior to allowing the employee to deliver any ElderChoices service(s). This orientation shall include, but not be limited to, a:

- description of the purpose and philosophy of the ElderChoices Program;
- discussion and distribution of the provider agency's written code of ethics;
- discussion of activities which shall and shall not be performed by the employee;
- discussion, including instructions, regarding ElderChoices record keeping requirements;
- discussion of the importance of the Plan of Care;
- discussion of the agency's procedure for reporting changes in the client's condition;
- discussion, including potential legal ramifications, of the client's right to confidentiality.

The Provider acknowledges it must attain the prior approval of the Division in the event a waiver service is to be rendered by an individual who is employed by or contracted with the provider agency and who is also related to the waiver participant.

Approval shall be requested by forwarding to the Division:

- the relationship between the waiver participant and the direct service provider;
- adequate justification for the service arrangement;
- documentation supporting that the family member meets the qualifications for providers of direct care; and
- a description of the strict controls implemented to assure payments are made to the family member for the specific service(s) rendered.

Under no circumstances may payment be made for services rendered by the waiver participant's:

1. Spouse
2. An adult's "guardian of the person," or
3. Anyone acting as an adult's "guardian of the person."

Family members or caregivers residing in the home with the client are prohibited from receiving reimbursement for direct provision of an ElderChoices service, with the exception of Adult Companion Service providers.

NOTE: Payment to a spouse, a legal guardian or anyone acting as a guardian of the person is not allowed for any provider type, including Adult Companion providers.

109 Reporting

The Provider agrees to notify the Division in writing of the resignation or termination of the agency's Director, Executive Officer or principal official and of any change in ownership within ten (10) working days of the action.

The Provider agrees to cooperate and assist in any efforts undertaken by DHS or the Division to evaluate the effectiveness of the program and agrees to comply with any findings and/or programmatic and accounting recommendations made either through an evaluation or audit conducted by the Department or its designee.

110 Control Policies

The Provider agrees to allow the Division the right to inspect its program sites, products, policies and procedures for the purpose of determining compliance with the terms of these assurances and any applicable laws and regulations.

111 Code of Ethics

The Provider agrees to develop, distribute and enforce a written code of ethics with each employee providing services to an ElderChoices client that shall include, but not be limited to, the following:

- No consumption of the client's food or drink;
- No use of the client's telephone for personal calls;
- No discussion of one's personal problems, religious or political beliefs with the client;
- No acceptance of gifts or tips from the client or their caregiver;
- No friends, relatives or unauthorized individuals are to accompany the employee to client's home;
- No consumption of alcoholic beverages or use of non-prescribed drugs prior to service delivery nor in the client's home,
- No smoking in the client's home;
- No solicitation of money or goods from the client;
- No breech of the client's privacy or confidentiality of records.

112 Independent Assessment

The Provider agrees to participate in an independent assessment of waiver services to evaluate quality of care, access to care and cost effectiveness.

113 Responsibilities of the Division of Aging & Adult Services

The Division of Aging & Adult Services (DAAS) will be responsible for the following:

- Oversight of all state and federally funded activities that involve service delivery to elderly persons;
- Maintaining a list of all enrolled ElderChoices waiver services providers
- Accepting client complaints with regard to delivery of ElderChoices waiver services. This shall include:

    1. Maintaining a file on all complaints;
    2. Investigating complaints, unless the Division determines that the complaint is without merit;
    3. Recording and filing the disposition and resolution of all complaints, indexed by provider name.

_____
Provider Name

Name of Principal Officer	Title
Signature of Principal Officer	Date
Signature of DAAS Director or Designee	Date

EDS Federal Corporation
Medicaid Provider Enrollment Unit
P.O. Box 8105
Little Rock, AR 72203-8105
(501) 376-2211 or 1-800-457-4454

EDS Federal Corporation will assign all Provider Identification Numbers (PIN). To prevent delays in receiving your PIN, double check to make sure that all forms in this packet are completed correctly.

Your Provider Identification Number will be mailed to you. If all pages of this packet are completed correctly, it will take approximately three weeks for you to receive a letter with your Arkansas Medicaid Provider Identification Number (PIN) and effective date.

You may not send in a claim until you have received your PIN.

PIN information is not available at the Alternatives office. Please DO NOT call us concerning that information. If it has been three weeks or more, please contact EDS at the numbers listed above.

ALL QUESTIONS REGARDING YOUR PROVIDER IDENTIFICATION NUMBER (PIN) MUST BE ANSWERED BY EDS. CALL (501) 376-2211 OR 1-800-457-4454 FOR ALL PIN INFORMATION.

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, 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. (MAY 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 _____ 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 eds.com. You may need to instruct your network administrator or e-mail provider to accept e-mails from eds.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) _____**E8**_____ B) _____C) _____

Code	Category Description
E4	ElderChoices H&CB 2176 Waiver - Chore services
E5	ElderChoices H&CB 2176 Waiver - Adult foster care
E6	ElderChoices H&CB 2176 Waiver - Home maker
E7	ElderChoices H&CB 2176 Waiver - Home delivered hot meals
EC	ElderChoices H&CB 2176 Waiver - Home delivered frozen meals
E8	ElderChoices H&CB 2176 Waiver - Personal emergency response systems
E9	ElderChoices H&CB 2176 Waiver - Adult day care
EA	ElderChoices H&CB 2176 Waiver - Adult day health care
EB	ElderChoices H&CB 2176 Waiver - Respite care

(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 []
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.

____ ____/____ ____
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.**

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

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 actual clearance date of paper checks. Your Medicaid Remittance Advice (RA) will continue to be mailed to the mailing address listed on your enrollment application.

If you wish to have your Medicaid payment automatically deposited, please complete the Authorization for Automatic Deposit and attach a **VOIDED CHECK OR A LETTER FROM THE BANK REFLECTING THE BANK'S ABA NUMBER AND YOUR ACCOUNT NUMBER.**

If you choose not to enroll in EFT, your checks along with your Medicaid RA will be mailed to you. **Please note that since EFT is available, checks are not available for pick-up at the EDS office.**

If you have any further questions concerning this letter, please contact the EDS Provider Assistance at (501) - 376-2211 (local or out-of-state) or 1-800-457-4454 (in-state WATS).

Sincerely,

Arkansas Department of Health and Human Services

Authorization for Automatic Deposit

Name of Medicaid Provider _____

Provider ID # _____ Taxonomy Code _____

Provider Address _____ Telephone Number _____

City, State _____ Zip Code _____

Type of Authorization ☐ New ☐ Change ☐ Cancel

☐ Checking ☐ Savings **(if not indicated will be automatically entered as checking)**

ABA Transit Number _____ Bank Account Number _____

A COPY OF A VOIDED CHECK OR A LETTER FROM THE BANK IS REQUIRED TO VERIFY THESE NUMBERS. THE NAME ON THE VOIDED CHECK OR LETTER FROM BANK MUST MATCH THE NAME OF THE MEDICAID PROVIDER STATED ABOVE. TEMPORARY CHECKS ARE INVALID IF THEY DO NOT HAVE THE PROVIDER'S NAME AND ADDRESS PRINTED BY THE BANK.

Name of Bank _____

Bank Address _____

City, State _____ Zip Code _____

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

_____
Provider's Original Signature (required)

Please return this form to:
Medicaid Provider Enrollment Unit
EDS
P.O. Box 8105
Little Rock, AR 72203-8105

(R. 4/07)

FORM W-9

REQUEST FOR TAXPAYER

IDENTIFICATION NUMBER AND CERTIFICATION

The Department of Finance and Administration and the Department of Human Services have mandated that an IRS form W-9 be completed by all vendors doing business with the Department of Human Services.

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II 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, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, 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. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

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: _____ (Signature Required)	By: _____ (Signature)
Name: _____ (Typed or Printed Name Required)	Name: _____ (Typed Name)
Title: _____ (Required)	Title: _____
Date: _____ (Required)	Date: _____
	Effective Date of Contract: _____

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#

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 #

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

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

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

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

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]

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:_____ 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).

   _____
   _____
   _____

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).

   _____
   _____
   _____

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).

   _____
   _____
   _____

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:_____
(Print or Type) (Print or Type)

Signature:_____ Date:_____