Navigating the Provider Certification Process

If you are applying as a NEW provider, complete steps ONE and TWO.
If you applying for a RENEWAL, complete step ONE only.

Step ONE: New and Renewal Applicants

- Find the new application or the renewal application at:

http://www.daas.ar.gov/provider_services.html

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

Step TWO: New Applicants ONLY

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

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

TIPS

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

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES-ELDERCHOICES PROGRAM

Provider Certification

STATE OFFICE USE ONLY

Reviewed by: _____ Date: _____

DOCUMENTS: _____ INS ____ LIC _____ IN-SER _____BKGR

NOTES:

CHECK APPLICATION TYPE: NEW ☐ OR RENEWAL ☐

Please Attach Only ONE Copy of Each Requested Document

Enter the appropriate Personal Identification Number (PIN)/Employer Identification Number (EIN); mark services for renewal; and complete the appropriate section(s) in the remainder of the application for service(s) offered. You will then email, fax or mail to one of the addresses provided on the application:

EIN (NEW)	PIN (RENEWAL)	SERVICES	COMPLETE SECTIONS
		☐ **Adult Companion**	**1, 2, 9**
		☐ **Adult Day Care**	**1, 3, 9**
		☐ **Adult Day Health Care**	**1, 3, 9**
		☐ **Chore**	**1, 4, 9**
		☐ **Home-Delivered Meals**	**1, 5, 9**
		☐ **Homemaker**	**1, 6, 9**
		☐ **Personal Emergency Response System**	**1, 7, 9**
		☐ **Respite Care** **Check One: In-Home ☐ or Facility-Based ☐**	**1, 8, 9**

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SECTION ONE—Provider Information (Please type or print)

Name of Provider | EIN Number (New)

Street and P.O. Box (if applicable) | PIN Number (Renewal)

City | State | Zip Code | County

Agency Contact Person

( ) | ( )

Telephone Number | Fax Number

E-Mail Address | Website

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

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

SECTION TWO—Adult Companion Provider

The following documents must be attached to the application:

- A copy of the agency's current Arkansas Department of **Health Class A** and/or **Class B License** as a Home Health Agency **or** the private care agency's (enrolled as a Medicaid personal care provider) Arkansas Department of **Health License as a personal care agency**.
- A current list of **criminal background check** for each employee and staff member.
- A list/calendar **of in-service training schedule** for the current year.
- Current proof of the agency's **Professional Medical Liability Insurance/Bonding Insurance**.

SECTION THREE—Adult Day & Adult Day Health Care Provider

The following documents must be attached to the application:

- A copy of the current **Adult Day Care** and/or **Adult Day Health Care Facility license** issued by the appropriate licensing and/or certifying agency.
- A current list of **criminal background check** for each employee and supervisor.
- A list/calendar **in-service training schedule** for the current year.
- Current proof of the agency's **Professional Medical Liability Insurance/Bonding Insurance**.

SECTION FOUR—Chore Provider

The following documents must be attached to the application if you provide **chore services along with personal care services**:

- A copy of the agency's current **Arkansas Department of Health Class A** and/or **Class B License** as providers of personal care and/or home health services.
- A current list of **criminal background check** for each employee and supervisor.
- A list/calendar **in-service training schedule** for the current year.
- Current proof of your agency's **Professional Medical Liability Insurance/Bonding Insurance**.

SECTION FIVE—Home-Delivered Meals Provider

The following documents must be attached to the application:

- A copy of current **Food Establishment Permit** issued by the Arkansas Department of Health.
- A list of the **minimum qualifications** for **staff and supervisors**. Documentation to support that the employee meets these qualifications should be maintained in the individual's personnel record.
- A current list of **criminal background check** of each employee, paid and volunteer, and supervisor.
- A copy of the agency's **written job descriptions** for each employee, paid and volunteer, and each supervisor.
- A copy of the agency's **written policy regarding the screening of applicants** for employment. Provide the job title and location of the individual(s) responsible for performing this function.
- A list/calendar of **in-service training sessions** that will be held during the upcoming certification period.
- Current proof of **Professional Medical Liability Insurance/Bonding Insurance**.

SECTION SIX— Homemaker Provider

The following documents must be attached to the application if you provide **Homemaker Services along with personal care services:**

- A copy of the agency's current Arkansas Department of **Health Class A and/or Class B License** as providers of personal care and/or home health services.
- A current list of **criminal background check** for each employee and supervisor.
- A list/calendar of **in-service training schedule** for the current year.
- Current proof of the agency's **Professional Medical Liability Insurance/Bonding Insurance**.

SECTION SEVEN—Personal Emergency Response System Provider

If you are applying as a NEW provider, complete steps TWO and THREE.
If you applying for a RENEWAL, complete steps ONE and TWO only.

PART I

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

□ **No** □ **Yes** **If yes, please list new number** _____

PART 2

The following documents must be attached to the application:

- A copy of the current **Underwriters Laboratories Certificate of Compliance** for Protective Signaling Services.
- List of **job descriptions** for all PERS staff.
- A current list of **criminal background check** for each employee and supervisor.
- A list/calendar of **in-service training schedule** for the current year.
- Current proof of your agency's **Professional Medical Liability Insurance/Bonding Insurance**.

PART 3

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

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

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

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

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

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

6. 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 EIGHT—Respite Provider

The following documents must be attached to the application when applying for certification as an **In-Home Respite Provider**:

- State Board of Health **Class A and/or Class B License** as providers of personal care and/or home health services.
- A current list of **criminal background check** for each employee and supervisor.
- A list/calendar of **in-service training schedule** for the current year.
- Current proof of the agency's **Professional Medical Liability Insurance/Bonding Insurance**.

An agency applying for certification as **Facility-Based Respite Provider** must attach **ONE** of the following documents:

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

AND copies of the following **THREE**:

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

SECTION NINE—Certification & Verification

I hereby certify that statements are true to the best of my knowledge and belief. I am aware that any willful misrepresentation of any material fact contained in or added as an attachment to this application will result in the denial of certification.

I have read and accept the regulations and provider assurances in the ElderChoices Medicaid Manual. Visit the following link and access Section II under Provider Manual:

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

I further affirm that eligibility for certification is contingent upon the agency's compliance with any federal, state or local licensure or certification requirements for the provisions of services.

Signature of Principal Official_____ SIGN HERE

Printed or Typed Name of Principal Official_____

Title_____Date_____

Please Attach:

Only ONE Copy of Each Requested Document

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Fax Number: 501.682.6245
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