Application for Annual Renewal of Attendant Care Provider Certification

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

September 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

As specified at Section 201.000 of the AAPD Medicaid Manual:

> It is the responsibility of all providers of Alternatives Waiver services to maintain current Division of Aging and Adult Services (DAAS) certification to avoid loss of provider eligibility. Required materials must be submitted to the Division of Aging and Adult Services. Certifications are renewed annually, with the exception of Agency Attendant Care providers, whose certifications are renewed every three years. If required recertification documents are not received by the Division of Aging and Adult Services prior to expiration of the current certificate, action will be taken to close the provider's identification number and Medicaid provider number. Payment cannot be authorized for services provided beyond the certification period.

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 Renewal 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-530
  Little Rock, AR 72203-1437

CLIENT INFORMATION

This form must be completed in full and included with your certification application. Please attach a copy of the legal document if a legal guardian or power of attorney manages your healthcare services and decisions. Make sure the client and the client's representative signs where appropriate.

Client Name: _____ **Medicaid #**_____

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

Choose and sign only 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.

I authorize the Decision-Making Partner to sign the employee's timesheets.

SIGN HERE

_____
Client Signature

Decision-Making Partner Name: _____

Telephone Number: _____

Email Address: _____

I understand as a Decision-Making Partner of the client that I cannot be a paid provider of Medicaid services.

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).

I authorize my spouse to sign the employee's timesheets.

SIGN HERE

_____
Client Signature

Spouse Name: _____

Telephone Number: _____

Email Address: _____

I understand as a spouse of the client that I cannot be a paid provider of Medicaid services.

SIGN HERE

_____
Spouse Signature

Option 4 _____ The 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. A copy of the current legal document **MUST** be included or on file for a legal representative.

I authorize the legal representative to sign the employee's timesheets.

SIGN HERE

_____
Client Signature

Legal Representative Name: _____

Authority Source: _____

Telephone Number: _____

Email Address: _____

I understand as a legal representative of the client that I cannot be a paid provider of Medicaid services

SIGN HERE

_____
Legal Representative Signature

IF NONE OF THE STATEMENTS ABOVE APPLY

Please contact the DAAS RN or CMS immediately.

The client's eligibility to self-direct must be re-assessed by the DAAS RN before an Attendant Care Provider Application can be reviewed.

APPLICATION FOR
AAPD CERTIFICATION / ATTENDANT CARE PROVIDER

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

_____
Attendant Care Provider Applicant's Mailing Address (where you want important documents mailed to you)

_____
City/State/Zip Code **Provider Identification Number (PIN)**

_____ _____
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, County **Zip Code** **Cell Phone Number**

Attendant Care Provider Signature _____ SIGN HERE **Date** _____

Client Signature _____ SIGN HERE **Date** _____

DAAS-9555 07/2014

PROVIDER ELIGIBILITY REQUIREMENTS

1. Are you legally responsible for the AAPD Beneficiary?

a. Spouse ___ YES ___ NO

b. Legal Guardian ___ YES ___ NO

c. Attorney-in-Fact ___ YES ___ NO

d. Decision-Making Partner chosen by beneficiary ___ YES ___ NO

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

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

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

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

___ YES ___ NO

4. 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)

_____ _____

_____ _____

_____ _____

5. 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

6. 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

(Continued on the following page)

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

___ YES ___ NO

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

___ YES ___ NO

If yes, please provide a brief description.

_____

_____

_____

_____

9. 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.

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

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

___ YES ___ NO

11. 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-530
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.