Division of Provider Services and Quality Assurance

APPLICATION FOR CERTIFICATION
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Check all that apply: ☐Initial application for certification
☐Notification (please specify); Certification #: _____

PROVIDER NAME: _____

PROVIDER ADDRESS: _____
Street *City* *County* *State* *Zip Code*

MAILING ADDRESS: _____
(if different) *Street* *City* *County* *State* *Zip Code*

CONTACT NAME: _____

CONTACT E-MAIL ADDRESS: _____ PHONE NUMBER: _____

TAXPAYER ID # (TIN or EIN): _____ HOURS OF OPERATION: _____

ADULT DAY HEALTH CENTER LICENSE #: _____

The applicant affirms receipt of the rules governing the certification of *Program of All-Inclusive Care for the Elderly (PACE)* and agrees to comply with these standards, as indicated by the signature below:

_____
Name of Applicant (print)

_____
Signature of Applicant Date

Submit applications to DPSQA.ProviderApplications@dhs.arkansas.gov.