Navigating the Provider Certification Process

If you are applying as a NEW provider, complete Parts A and B.
If you applying for a RENEWAL, complete Part A only.

Part A — New and Renewal Applicants

- Find the new/renewal application:

  https://humanservices.arkansas.gov/about-dhs/dpsqa/agency-provider-certification

- 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:** **DPSQA.ProviderApplications@dhs.arkansas.gov**
  - **Fax Number:** **501-682-6245**
  - **Mailing Address:** **DHS/DPSQA**
    ATTN: Certification Unit
    PO BOX 1437-Slot S530
    Little Rock, AR 72203-1437

Part B — New Applicants ONLY

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

  https://portal.mmis.arkansas.gov/armedicaid/provider/Home/ProviderEnrollment/tabid/477/Default.aspx

- 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. Please allow **30-60 days for processing**.
- The DPSQA Certification Unit will mail you a certificate with your PIN and expiration date when all steps have been completed!

Targeted Case Management Provider Application

STATE OFFICE USE ONLY

Reviewed by: _____ Date: _____

DOCUMENTS: ____ INS ____ LIC ____ IN-SER ____ BKGR

NOTES: _____

Date Completed _____

NEW Application ☐ **OR RENEWAL Application** ☐

Please Attach Only ONE Copy of Each Requested Document

Provider Name _____

SECTION ONE—Provider Information (Please type or print)

Corporate Name EIN

DBA Name

Street Address and/or PO Box City State Zip Code

( )

Contact Person Title Telephone Number

E-Mail Address Website

Mailing address if different from above:

Street Address and/or PO Box City State Zip Code

Email Address: DPSQA.ProviderApplications@dhs.arkansas.gov
Fax Number: 501.682.6245
Mailing Address: DHS/DPSQA
ATTN: Certification Unit
PO BOX 1437-Slot S-530 Little Rock, AR
72203-1437

SECTION TWO—Application Attachments/Experiences

Please check below, which applies:

____ Licensed as a **Class A Home Health Agency by the Arkansas Department of Health (attach a copy of your agency's Class A Home Health Agency license** that your agency will be operating under for the period _____.) Since you will not receive this license from the Department of Health until sometime in January, please send a copy as soon as it is received.

____ Licensed as a **Class B Home Health Agency by the Arkansas Department of Health (attach a copy of your agency's Class B Home Health Agency license** that your agency will be operating under for the period _____.) Since you will not receive this license from the Department of Health until sometime in January, please send a copy as soon as it is received.

____ A **Unit of State Government** (specify) _____
(Attach some form of documentation for the period _____documenting that your agency is a "Unit of State Government")

____ Other Agency (specify) _____
(Attach a copy of **one** of the following for the period _____:

- Your agency's **Private Care Agency - Medicaid Personal Care license** through the Arkansas Department of Health; **or**
- Your agency's **Adult Day Services license** or **Adult Day Health Services license** through the Division of Medical Services, Office or Long Term Care; **or**
- Your agency's **services provider certificate** issued through the Division of Aging & Adult Services; **or**
- Your agency's **Articles of Incorporation** from the Arkansas Secretary of State's Office; **or**
- **Some other form of documentation** that your agency is an "Agency."

If you checked "other agency," please supply the following answers:

1. This agency has performed case management services from _____ to _____. Please indicate to whom the agency has performed case management services.

2. This agency has worked specifically in the field of aging from _____ to _____.

ATTACH the following requested documents to this application:

- A spreadsheet of a current list of a **criminal background check** for each employee and supervisor.

FULL NAME	Have you lived continuously in Arkansas for the last 5 years?	Have you lived in another state within the past 5 years? If so, what state?	Date of Last Background Check
John Lewis Doe	No	List State(s)	01/15/2014
Sarah Jane Doe	Yes	Arkansas	06/08/2012

- A copy of **liability insurance or bond**.
- A copy **of in-service training schedule** for each employee and supervisor for the past year.
- If required, a copy of your agency's **license** issued by the Arkansas Department of Health (**1-800-462-0599**).

SECTION THREE—Provider Assurances Verification

A. Agency Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an ARChoices Waiver Person-Centered Service Plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. **The Department of Human Services requires mandatory training. The Provider must attend one of the two provider workshop trainings in the calendar year. Failure to attend one of these trainings could jeopardize the provider's certification for the waiver.** The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to an ARChoices beneficiary.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
    a. Description of the purpose and philosophy of the ARChoices Waiver Program;
    b. Discussion and distribution of the provider agency's written code of ethics;
    c. Discussion of activities which shall and shall not be performed by the employee;
    d. Discussion, including instructions, regarding ARChoices Waiver record keeping requirements;
    e. Discussion of the importance of the PCSP;
    f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
    g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality;
    h. Discussion of the beneficiary's rights regarding HCBS Settings as discussed in 201.000.

B. Code of Ethics

The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver beneficiary a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

C. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
    a. Choice must be identified/included in the person-centered service plan.
    b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
6. In a provider-owned or controlled residential setting (e.g., Adult Family Homes), in addition to the qualities specified above, the following additional conditions must be met:
    a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
    b. Each individual has privacy in their sleeping or living unit:
        i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
        ii. Beneficiaries sharing units have a choice of roommates in that setting.
        iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
    c. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
    d. Beneficiaries are able to have visitors of their choosing at any time.
    e. The setting is physically accessible to the individual.
    f. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
        i. Identify a specific and individualized assessed need.
        ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
        iii. Document less intrusive methods of meeting the need that have been tried but did not work.
        iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

I have read and agree to the Provider Assurance agreement.

Signature of Principal Official_____ SIGN HERE

Printed or Typed Name of Principal Official_____

Title_____Date_____

Email Address: DPSQA.ProviderApplications@dhs.arkansas.gov
Fax Number: 501.682.6245
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ATTN: Certification Unit
PO BOX 1437-Slot S-530 Little Rock, AR 72203-1437

Provider Name _____

SECTION FOUR – Counties Served

The following information is required to process this application. Please check the following box(es) of the county/counties listed below where you will provide services to clients within a 50-mile radius of your physical location(s).

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

IMPORTANT: The effective date of this certification does **NOT** establish Medicaid eligibility for the ARChoices client and does not guarantee Medicaid payment.