arkansas total care

Enrollment Application

ATTACHMENTS NEEDED. Please include the following items for each location with your completed form:

- ☐ Completed W-9 (fill out a separate W-9 for each Tax ID used at your practice)
- ☐ Completed, signed, and dated Disclosure of Ownership Form
- ☐ Copy of current State License/Approval (as applicable)
- ☐ Copy of Medicare/Medicaid Participation Certification (as applicable)
- ☐ Copy of Declaration Sheet and/or Certificate of Insurance
  - ☐ **Home and Community Based Services (HCBS) Providers** who are not providing medical or behavioral health service: General Liability Insurance policies
  - ☐ **All other provider types: BOTH** current Professional Malpractice and Comprehensive General Liability Insurance policies
- ☐ Signed and dated Participating Provider Agreement
- ☐ Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/ JCAHO/ CARF/COA/or AOA) Accreditation letter with dates of accreditation (if applicable)
- ☐ If not accredited by a nationally recognized accrediting body, attach the Site Evaluation results from a governmental agency (if applicable)

Instructions: Please print legibly or type this application in its entirety using N/A where applicable. Please return via:

Email: ArkCredentialing@centene.com

Fax: 844-357-7890

Standard mail:

Arkansas Total Care

ATTN: Credentialing

P.O. Box 25538

Little Rock, AR 72212

License or Certification Type – Choose all that apply and provide License # or Certification

☐ Behavioral Therapy:	☐ Nursing Facility:
☐ Adult Daily Living (Residential Care):	☐ Nutritional Counseling:
☐ Cognitive Therapy:	☐ Personal Assistant Services:
☐ Durable Medical Equipment:	☐ Personal Assistant Services (CSLA):
☐ Home Health Agency:	☐ Respite:
☐ Home Modification:	☐ Other (please describe):
☐ Other (please describe):	☐ Other (please describe):

Legal Information

Legal Name:	Tax ID:	Medicaid Certified? Yes ☐ No ☐
DBA (if applicable):	Is Tax ID held for all locations? Yes ☐ No ☐	If answered NO above, provide Tax ID for each applicable location:
Profit/Non-Profit:	National Provider ID (NPI) if applicable:	2nd National Provider ID (NPI) if applicable:
3rd National Provider ID (NPI) if applicable:	PROMISe™ ID/Medicaid Number:	Medicare Number:
Website URL:		

Billing Information

Pay To:		
Pay to Address:	City/State/Zip:	Phone:

Mailing Information

Attn:		
Address:	City/State/Zip:	Phone:
Fax:	Email:	
If provider has more than one group NPI number – will all billing and mailing needs be serviced through the same address noted here? Yes ☐ No ☐ If "No", please attach additional addresses.		

Primary Facility/Primary Office Information

Is this a participant service site? Yes ☐ No ☐ *(list all service sites separately below, if not enough room provide on separate sheet of paper)*		
Name (Doing business as):		
Telephone:	Primary Contact Name:	E-Mail:
Address (Street):	City/State/Zip:	County:
Credentialing/Billing Contact:	Fax:	E-Mail:
Website URL:		Medicaid Number:

SERVICE HOURS	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:
	Are PAs, CNMs, and/or Nurse Practitioners used? Yes ☐ No ☐			Will you be accepting any new participants? Yes ☐ No ☐			
In addition to English -Please list all languages used to communicate with participants (including American Sign Language if applicable):							
Is a skilled medical interpreter available? Yes ☐ No ☐				Has staff been trained on cultural competency ? Yes ☐ No ☐			
Is your practice limited to certain ages? Yes ☐ No ☐				*If yes, please list age/gender restrictions:*			

Are the following area(s) ADA compliant? (Check those that apply)

☐ Parking	☐ ADA Compliant Signage
☐ Interior Building	☐ Medical Equipment
☐ Restrooms	☐ Exam Room
Are you located within walking distance of a public transportation route? Yes ☐ No ☐	

Capacity on Certificate of Compliance

Residential Facility-Capacity (# of residents):	Adult Day Care (# of participants):
Personal Assistance Service: Do you use Electronic Visit Verification? Yes ☐ No ☐	If yes, vendor:
Home Health Service: Do you use Electronic Visit Verification? Yes ☐ No ☐	If yes, vendor:

Malpractice Insurance Information (if applicable)

Carrier Name:	Insured Amount:	Effective Date:
Expiration Date:	Policy #:	
Aggregate Coverage Amount:		

General Liability Insurance Information

Carrier Name:	Insured Amount:	Effective Date:
Expiration Date:	Policy #:	Coverage per Occurrence:
Aggregate Coverage Amount:		

Secondary Facility/Primary Office Information

Is this a participant service site? Yes ☐ No ☐ (list all service sites separately below on page 6)		
Name (Doing business as):		
Telephone:	Primary Contact Name:	E-Mail:
Address (Street):	City/State/Zip:	County:
Credentialing/Billing Contact:	Fax:	E-Mail:
Website URL:		Medicaid Number:

SERVICE HOURS	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:
	Are PAs, CNMs, and/or Nurse Practitioners used? Yes ☐ No ☐			Will you be accepting any new participants? Yes ☐ No ☐			
In addition to English -Please list all languages used to communicate with participants (including American Sign Language if applicable):							
Is a skilled medical interpreter available? Yes ☐ No ☐				Has staff been trained on cultural competency? Yes ☐ No ☐			
Is your practice limited to certain ages? Yes ☐ No ☐				*If yes, please list age/gender restrictions:*			

Are the following area(s) ADA compliant? (Check those that apply)

☐ Parking	☐ ADA Compliant Signage
☐ Interior Building	☐ Medical Equipment
☐ Restrooms	☐ Exam Room
Are you located within walking distance of a public transportation route? Yes ☐ No ☐	

Capacity on Certificate of Compliance

Residential Facility-Capacity (# of residents):	Adult Day Care (# of participants):
Personal Assistance Service: Do you use Electronic Visit Verification? Yes ☐ No ☐	If yes, vendor:
Home Health Service: Do you use Electronic Visit Verification? Yes ☐ No ☐	If yes, vendor:

Malpractice Insurance Information (if applicable)

Carrier Name:	Insured Amount:	Effective Date:
Expiration Date:	Policy #:	
Aggregate Coverage Amount:		

General Liability Insurance Information

Carrier Name:	Insured Amount:	Effective Date:
Expiration Date:	Policy #:	Coverage per Occurrence:
Aggregate Coverage Amount:		

Arkansas Counties:

01. Arkansas	16. Craighead	31. Howard	46. Miller	61. Randolph
02. Ashley	17. Crawford	32. Independence	47. Mississippi	62. Saint Francis
03. Baxter	18. Crittenden	33. Izard	48. Monroe	63. Saline
04. Benton	19. Cross	34. Jackson	49. Montgomery	64. Scott
05. Boone	20. Dallas	35. Jefferson	50. Nevada	65. Searcy
06. Bradley	21. Desha	36. Johnson	51. Newton	66. Sebastian
07. Calhoun	22. Drew	37. Lafayette	52. Ouachita	67. Sevier
08. Carroll	23. Faulkner	38. Lawrence	53. Perry	68. Sharp
09. Chicot	24. Franklin	39. Lee	54. Phillips	69. Stone
10. Clark	25. Fulton	40. Lincoln	55. Pike	70. Union
11. Clay	26. Garland	41. Little River	56. Poinsett	71. Van Buren
12. Cleburne	27. Grant	42. Logan	57. Polk	72. Washington
13. Cleveland	28. Greene	43. Lonoke	58. Pope	73. White
14. Columbia	29. Hempstead	44. Madison	59. Prairie	74. Woodruff
15. Conway	30. Hot Spring	45. Marion	60. Pulaski	75. Yell

Services – Check each that applies. For "Service County", list corresponding county number from above.

Service	Service County	Address	Location ID
☐ Adult Daily Living (261QA0600X)			
☐ Assistive Technology			
☐ Benefits Counseling			
☐ Career Assessment (261QA0600X)			
☐ Community Integration (251S00000X)			
☐ Community Transition Svcs (251J00000X)			
☐ Employment Skills Development (251E00000X)			
☐ Financial Management Services Services My Way (251X00000X)			
☐ Financial Management Services Start UP (251X00000X)			
☐ Home Adaptations (171WH0202X)			
☐ Home Delivered Meals (332U00000X)			
☐ Home Health Aide (374U00000X)			
☐ Home Health-Nursing (LPN)			
☐ Home Health-Nursing (RN)			

Service	Service County	Address	Location ID
☐ Home Health-Occupational Therapy (225X00000X)			
☐ Home Health-Occupational Therapy-Assist (225X00000X)			
☐ Home Health-Physical Therapy (225X00000X)			
☐ Home Health-Physical Therapy-Assist (225100000X)			
☐ Home Health-Speech & Language Therapy			
☐ Job Coaching (251E00000X)			
☐ Non-medical Transportation (343900000X)			
☐ Nursing Facility Services			
☐ Participant-Directed Community Supports (251X00000X)			
☐ Participant-Directed Goods & Services (251X00000X)			
☐ Personal Care Attendant (3747P1801X)			
☐ Personal Emergency Response System (33300000X)			
☐ Prevocational Services (251S00000X)			
☐ Residential Habilitation (320900000X)			
☐ Respite (Agency) (253Z00000X)			
☐ Respite (Consumer) (385H00000X)			
☐ Service Coordination			
☐ Specialized Medical Equipment and Supplies			
☐ Structured Day Habilitation (320900000X)			
☐ Support Employment			
☐ Transition Service Coordination			
☐ Vehicle Modifications (171WV0202X)			
☐ Other			
☐ Other			

Confidential Information | Have you, any agent, or managing employee ever:

Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?	**Yes** ☐	**No** ☐
Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?	**Yes** ☐	**No** ☐
Had a controlled drug license withdrawn?	**Yes** ☐	**No** ☐
Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?	**Yes** ☐	**No** ☐
In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?	**Yes** ☐	**No** ☐

Signature of authorized designee | **Title**

Name (Print) | **Date**

Attestation Statement

INSTRUCTIONS: Please complete either Section A or Section B for consideration to participate in the Health Plan provider network. For any "Yes" response to one or more of the questions in Section B, please provide separate page with explanations for all "Yes" responses.

This attestation pertains to all employed and contracted provider(s) authorized to provide or supervise care provided by _____ (the "Agency").

I, _____, the undersigned representative of Agency, on its behalf, understand and agree that as part of the credentialing process for participation in the Health Plan provider network,

Section A

...attest that the Agency has conducted the following on each caregiver prior to allowing each to provide care to a Health Plan member:

- Conducted Criminal Background Check and;
- Reviewed State Child Maltreatment Registry and;
- Reviewed State Adult Maltreatment Registry and;
- Successfully Passed Drug Screening
- Confirmed Active Driver's License (if applicable)
- A completed job application that contains any required credentials for the position
- Completed reference checks

Section B

...assure through a background check and other reasonable means the following with respect to each caregiver providing care and each attendant supervising care on behalf of the Agency:

Have applicable license(s) held by caregiver(s) and/or attendant(s) been revoked, refused, restricted or voluntarily surrendered?	**Yes** ☐	**No** ☐
Have caregiver(s) and/or attendant(s) been convicted of, or pled guilty to, a felony?	**Yes** ☐	**No** ☐
Has any caregiver or attendant been terminated, suspended, barred, sanctioned or voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program?	**Yes** ☐	**No** ☐
Is/Are caregiver(s) and/or attendant(s) unable to perform the essential functions of his or her job with reasonable accommodation?	**Yes** ☐	**No** ☐
Is the Agency aware of any reason why caregiver(s) and/or attendant(s) may pose a threat to the person or property of individuals receiving care provided by caregiver(s) or supervised by attendant(s)?	**Yes** ☐	**No** ☐

Signature of authorized designee **Title**

Name (Print) **Date**

Tax ID