Summit
COMMUNITY CARE

HCBS Provider 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/home- and community-based services (HCBS) certificate issued by Arkansas Division of Provider Services and Quality Assurance (as applicable)
☐ Copy of Medicaid Participation Certification (as applicable)
☐ Copy of declaration sheet and/or certificate of insurance
☐ 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 letter (by a nationally recognized accrediting body, such as TJC/JCAHO/ CARF/COA/or AOA) 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: providers@summitcommunitycare.com
Fax: 855-717-4548
Mail:
Summit Community Care
Attn: LTSS Provider Specialty Team
650 S. Shackleford Rd. Suite 440
Little Rock, AR 72211

Legal information
Legal name: _____
Tax ID: _____
Medicaid certified?
☐ Yes ☐ No
Doing business as (DBA) (if applicable): _____
Is tax ID held for all locations?
☐ Yes ☐ No
If answered no above, provide tax ID for each applicable location:
Profit/nonprofit: National Provider ID (NPI) if applicable: _____
2nd NPI (if applicable): _____
3rd NPI (if applicable): _____
Website URL: _____

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 (DBA): _____
Telephone: _____
Primary contact name: _____
E-mail: _____
Street address: _____
City/State/ZIP: _____ County: _____
Credentialing/billing contact: _____
Fax: _____
E-mail: _____
Website URL: _____
Medicaid number(s): _____

Service hours
Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____
Friday: _____ Saturday: _____ Sunday: _____

Are physician assistants, certified nurse midwives, and/or nurse practitioners used?
☐ Yes ☐ No
Will you be accepting any new participants?
☐ Yes ☐ No
In addition to English, 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) *Americans with Disabilities Act* (*ADA*) compliant? (Mark those that apply):
☐ Parking
☐ Restrooms
☐ Medical equipment
☐ Interior building
☐ Signage
☐ Exam room
Are you located within walking distance of a public transportation route? ☐ Yes ☐ No

General liability insurance information
Carrier name: _____
Insured amount: _____
Effective date: _____ Expiration date: _____ Policy #: _____
Coverage per occurrence: _____
Aggregate coverage amount: _____

Billing information
Pay to: _____
Pay to address: _____
City/State/ZIP: _____
Phone: _____

Correspondence address
Attention: _____
Address: _____City/State/ZIP: _____
Phone: _____
Fax: _____
Email: _____

If provider has more than one group NPI number/Medicaid ID, does the billing and correspondence address apply to each?
☐ Yes ☐ No

If **No**, please attach additional addresses.

Arkansas counties:

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

Services
Mark each that applies. For **service county**, list corresponding county number from above.

Service	Service county	Address	Medicaid ID
☐ Adult rehabilitative day service			
☐ Adaptive equipment			
☐ Assistive technology			
☐ Adult life skills development			
☐ Behavioral assistance			
☐ Community integration			
☐ Community transition services			
☐ Consultation services			
☐ Child and youth support services			
☐ Crisis intervention			
☐ Enabling technology			
☐ Environmental modifications			
☐ Emergency respite			
☐ Family support partners			
☐ Group life skills development			
☐ Home delivered meals			
☐ Individual life skills development			
☐ Job coaching			
☐ Mobile crisis intervention			
☐ Non-medical transportation			

☐ Partial hospitalization			
☐ Personal care			
☐ Peer support			
☐ Personal emergency response system			
☐ Pharmacologic counseling by RN			
☐ Planned Respite			
☐ Prevocational services			
☐ Recovery support partners			
☐ Residential community reintegration program			
☐ Residential habilitation			
☐ Specialized medical equipment and supplies			
☐ Structured day habilitation			
☐ Substance abuse detox (observational)			
☐ Supported employment (CES)			
☐ Supportive employment (OBH)			
☐ Supportive living/caregiver respite/supplemental supports			
☐ Supportive housing			
☐ Therapeutic communities			
☐ Therapeutic host homes			
☐ Vehicle modifications			
☐ Other			
☐ Other			
☐ Other			
☐ Other			

Disclosure questions:

1. Has your organization's license ever been restricted, conditioned, suspended, or terminated? ☐ Yes ☐ No
2. In the most recent 12 months, has your organization lost its licensure/certification/accreditation? ☐ Yes ☐ No
3. Does your organization have any current state or federal actions or limits including Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed, or terminated your participation for reasons related to professional competence or conduct? ☐ Yes ☐ No
4. Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program? ☐ Yes ☐ No
5. Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)? ☐ Yes ☐ No
6. Have you ever been disciplined for a violation of ethical standards by a professional organization? ☐ Yes ☐ No
7. To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

If you answered yes to any of the above questions, please attach a written explanation.

Authorizations, attestation, and release
I, the undersigned authorized agent, hereby attest that the information submitted in or in support of this application is true, accurate and complete to the best of my knowledge and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of privileges, employment, or participating agreement. A photocopy of this document shall be as effective as the original.

*X*_____ _____

Signature of authorized designee Title

_____ _____ _____

Name (print) Date Tax ID