Summit COMMUNITY CARE

Arkansas | Medicaid

Home- and Community-based Services Provider Enrollment Application

Instructions: Print legibly or type this application in its entirety using N/A where applicable. Please return via email at providers@summitcommunitycare.com or fax at **855-717-4548**.

Please indicate:	
☐ New contract (check all service offerings)	
☐ Adding a new service(s): (check only the new service offering(s) below)	Effective date:
☐ Terming a service(s)	Effective date:
Attachments needed: 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 the 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	
☐ 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)	

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, please provide tax ID for each location:	
NPI (if applicable):	☐ Profit or ☐ Non-profit
Website:	

Primary facility/office information		
Is this a participant service site? ☐ Yes ☐ No		
List all service sites separately below. If there is not enough room, provide information on a separate sheet of paper.		
Name (DBA):		
Primary contact name:		
Telephone:	Email address:	
Street address:		
City, state, ZIP:	County:	
Credentialing/billing contact:		
Fax:	Email:	
Website:	Medicaid number(s):	
Service hours		
Monday:	Tuesday:	Wednesday:
Thursday:	Friday:	Saturday:
Sunday:		
Are physician's assistants (PAs), certified nurse midwives (CNAs), or nurse practitioners (NPs) 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:		
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 areas *American with Disabilities Act* compliant (mark those that apply):					
☐ Parking	☐ Restrooms	☐ Medical equipment	☐ Interior building	☐ Signage	☐ Exam room

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

Billing information	
Pay to:	
Pay to address:	
City, state, ZIP:	
Phone:	

Correspondent address:	
Attention:	
Address:	
City, state, ZIP:	
Phone:	Fax:
Email:	

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

If no, 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 the corresponding county number from the previous table.			
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 a registered nurse (RN)			
☐ Planned respite			
☐ Prevocational services			
☐ Recovery support partners			
☐ Residential community reintegration program			
☐ Residential habilitation			
☐ Specialized medical equipment and supplies			
☐ Structured day habilitation			
☐ Substance use disorder detox (observational)			
☐ Supported employment (CES)			

Services: Mark each that applies. For service county, list the corresponding county number from the previous table.			
Service	Service county	Address	Medicaid ID
☐ Supportive employment (OBH)			
☐ Supportive living/caregiver respite/supplemental supports			
☐ Supportive housing			
☐ Therapeutic communities			
☐ Therapeutic host homes			
☐ Vehicle modifications			
☐ Other			
☐ Other			
☐ Other			
☐ Other			

Disclosure questions:

- Has your organization's license ever been restricted, conditioned, suspended, or terminated? ☐ Yes ☐ No
- In the most recent 12 months, has your organization lost its licensure/certification/accreditation? ☐ Yes ☐ No
- 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, not approved, or not renewed your participation for reasons related to professional competence or conduct? ☐ Yes ☐ No
- Have you ever been or are you currently excluded from participation with Medicare or any other federally funded healthcare program? ☐ Yes ☐ No
- Has your professional liability coverage ever been limited, not approved, not renewed, or special rated (for reasons other than the carrier's end of operations in your state)? ☐ Yes ☐ No
- Have you ever been disciplined for violating ethical standards by a professional organization? ☐ Yes ☐ No
- To your knowledge, has information about you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

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 the denial of application or termination of privileges, employment, or participating agreement.

A photocopy of this document shall be as effective as the original.

Signature of authorized designee		Title
Name (print)	Date	Tax ID