Certification and Medicaid Provider Application

Attendant Care for a Beneficiary of the
ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES
Medicaid Waiver Program

DIVISION OF AGING & ADULT SERVICES
ARKANSAS DEPARTMENT OF HUMAN SERVICES

January 2013

The Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program

The Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program allows enrolled beneficiaries to receive services at home, as opposed to an in-patient care facility. Please refer to the *Alternatives for Adults with Physical Disabilities Waiver Program Medicaid Manual* for regulations. The manual is available at:

https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/apdwvr.aspx

The offer of employment does not indicate approval as a Medicaid Provider. You are not authorized to begin work as a Medicaid Provider until and unless you are approved.

This office will review your application to ensure you meet the eligibility requirements published in the Medicaid Manual. Your application will then be considered according to the eligibility standards of all Medicaid Providers. The beneficiary's Home and Community-Based Services nurse/counselor or Counseling and Support Manager (CSM) will alert your employer when a determination on your Medicaid Provider Application is made.

BENFICIARY/EMPLOYER INFORMATION

This form must be completed in full and included with your certification application. If the beneficiary has a legal guardian or an attorney-in-fact who holds authority to manage the beneficiary's healthcare services and decisions, a copy of the court document/legal instrument that established the authority must be included.

Beneficiary's Name: _____ **Medicaid #** _____

Medicaid Provider Applicant's Name: _____ **Date:** _____

Check One:

_____ The beneficiary will perform <u>all</u> employer tasks without any assistance (recruiting, hiring, training, supervision, terminating, monitoring my timesheets and approving payment).

_____
Beneficiary/Employer's Signature

_____
HCBS Nurse/Counselor or CSM

_____ The beneficiary will perform all employer tasks with assistance from a Decision-Making Partner.

_____
Beneficiary/Employer's Signature

Name of Decision-Making Partner: _____

Telephone Number: _____

Email Address: _____

Is the Decision-Making Partner authorized to sign your employee's timesheets?

___ YES ___ NO

_____
Decision-Making Partner's Signature

_____
HCBS Nurse/Counselor or CSM

_____ The beneficiary's spouse will perform all employer tasks (recruiting, hiring, training, supervision, terminating, monitoring my timesheets and approving payment).

Name of Spouse/Employer: _____

Telephone Number: _____

Email Address: _____

_____
Spouse/Employer's Signature

_____ A legal representative (i.e. legal guardian or attorney-in-fact) performs all employer tasks (recruiting, hiring, training, supervision, terminating, monitoring my timesheets and approving payment) for the beneficiary.

Name of Legal Representative/Employer: _____

Authority Source: _____

Telephone Number: _____

Email Address: _____

_____ The court document/legal instrument that grants authority to perform the duties of employer for the beneficiary's care providers is attached.

_____
Legal Representative/Employer's Signature

IF NONE OF THE STATEMENTS ABOVE APPLY:

Please contact the HCBS nurse/counselor or CMS immediately.

The beneficiary's eligibility to self-direct must be re-assessed before a Certification/Medicaid Provider Application can be reviewed.

APPLICATION FOR
AAPD CERTIFICATION / MEDICAID PROVIDER

_____ _____ _____

Medicaid Provider Applicant's First Name **MI** **Last Name**

_____

Mailing Address (where you want important documents to be mailed)

_____

City/State/Zip Code

_____

Street Address (where you live)

_____

City/State/Zip Code

_____ _____

Home Phone (Area Code and Number) **Cell Phone** (Area Code and Number)

_____

E-Mail Address

_____ _____

Name of the AAPD Beneficiary who indicated an interest in hiring you **Medicaid Number**

_____ _____

AAPD Beneficiary's Home Address **Home Phone Number**

_____, AR _____ _____

City **Zip Code** **Cell Phone Number**

PROVIDER ELIGILBILITY REQUIREMENTS

1. Are you legally responsible for the AAPD Beneficiary?

a.	Spouse	___ YES	___ NO
b.	Legal Guardian	___ YES	___ NO
c.	Attorney-in-Fact	___ YES	___ NO
d.	Decision-Making Partner chosen by the Beneficiary	___ YES	___ NO

2. Are you 18 years of age or older? ___ YES ___ NO

a. Date of Birth: _____
mm/dd/year

b. Place of Birth: _____
City/State/County

3. Are you a United States citizen or legal immigrant authorized to work in the U.S?

___ YES ___ NO

4. Are you free from evidence of the following?

a.	Abuse or fraud in any setting	___ YES	___ NO
b.	Violations in the care of a dependent population	___ YES	___ NO
c.	Conviction of a crime related to a dependent population	___ YES	___ NO
d.	Conviction of a violent crime	___ YES	___ NO

5. **Are you able to read and write at a level sufficient to follow written instructions and maintain records?**

___ YES ___ NO

If no, identify the person who will read written instructions to the applicant:

Name of Assistant: _____

Telephone Number: _____

Email Address: _____

_____

Assistant's Signature

6. **Are you able to do simple math in order to complete billing claim forms.**

___ YES ___ NO

If no, identify the person who will perform this task for the applicant:

Name of Assistant: _____

Telephone Number: _____

Email Address: _____

_____

Assistant's Signature

NOTE: To justify payment of Medicaid funds during audits, written claim forms that reflect the actual time worked must still be prepared, complete with signatures, and maintained, even if claims are submitted electronically.

Do you accept this requirement? ___ YES ___ NO

7. **Are you in adequate physical health to perform the job tasks required?**

___ YES ___ NO

8. **Do you have any disease that can be transmitted through casual contact?**

___ YES ___ NO

9. **Are you a state employee?** ___ YES ___ NO

____ If yes, attach a written waiver of § 19-11-705, which refers to employee conflict of interest, by the director of the Department of Finance and Administration granting permission to proceed with the transaction to such extent and upon such terms and conditions as may be specified. Such waiver and permission may be granted when the interests of the state so require or when the ethical conflict is insubstantial or remote.

10. **Have you read and do you accept the regulations published in the AAPD Medicaid Manual?**

https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/apdwvr.aspx

___ YES ___ NO

Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program

Service Agreement between
Beneficiary/Legal Representative Employer
and
Attendant Care Provider Employee

Beneficiary: _____

Legal Representative: _____
(if applicable)

Attendant Care Provider Hiring Choice: _____

As beneficiary or legal representative of a beneficiary in the AAPD program, I have chosen to self-direct by hiring the above-mentioned individual as AAPD Attendant Care Provider, and, as such, I am the employer. I understand that, as employer, it is my responsibility to train, manage and terminate, if necessary, this attendant care provider/employee, as well as monitor the employee's claims/timesheets for accuracy and approve payment.

As employer, I will direct the attendant care provider/employee to deliver the types of services as outlined in Medicaid policy and in accordance with the Plan of Care. I also will direct the schedule this attendant care provider/employee will follow.

I understand I must comply with the AAPD Medicaid policies.

This agreement will automatically terminate on the date this employee's Provider Certification expires, unless terminated earlier by me.

_____ _____
Employer Signature Date
Beneficiary/Legal Representative

_____ _____
Employee Signature Date

Arkansas Department of Human Services
Participant Exclusion Rule
DHS Policy 1088

The term "participant" in this policy means a person seeking to become a party to a contract with DHS to furnish services (i.e. AAPD Attendant Care Medicaid Provider).

1088.1.1 Purpose

DHS shall conduct business only with responsible participants. Participants will be excluded from participation in DHS programs not as penalty, but rather to protect public funds, the integrity of publicly funded programs, and public confidence in those programs. It is also the intent of this policy to prevent excluded participants from substituting others, usually immediate family members, as surrogates to continue the practices that caused DHS to exclude the participant.

1088.2.3 Causes for Exclusion

DHS shall automatically exclude a participant if the participant is the subject of final determination that the participant has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or *nolo contendere*, to any crime related to:

A. Obtaining, attempting to obtain, or performing a public or private contract or subcontract

B. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty

C. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony

D. Federal antitrust statutes

E. The submission of bids or proposals

F. Any physical or sexual abuse or neglect when the offense is a felony

Based on this policy, all AAPD Medicaid Provider Applicants must understand and acknowledge the following:

Your application will be provided to HP Enterprises, a Medicaid Contractor, to ensure that all qualifications required of a Medicaid Provider of AAPD Attendant Care are met. Your application's review will include a national and state background check to

determine if you are placed on the DHS Provider Exclusion List or have a criminal record that contains a conviction. If a positive finding results, it will be reviewed by legal staff within the Medicaid Program Integrity Section, who will advise HP on whether a Medicaid Provider Identification Number (PIN) can be assigned.

You will be made aware of any adverse decision in writing by the Medicaid Program Integrity Section, along with what action to take if you desire to appeal the decision.

Medicaid Provider Applicant Acknowledgement:

By signing below, you indicate that you have read and understand the provided portions of DHS Policy 1088:

_____

Medicaid Provider Applicant's Printed Name

_____ _____

Medicaid Provider Applicant's Signature **Date**

INSERT

APS FORM

INSERT TAX FORMS

INSERT MEDICAID APPLICATION