**Please include the following with your application:**

☐ Completed W-9 (include separate W-9 for each Tax-ID used at your practice)

☐ Signed Provider Participation Agreement

☐ Copy of current State License

☐ Copy of Arkansas Medicaid Participation Certification

☐ Attestation of Facility

☐ HCBS Provider Attestation

☐ Completed Provider Roster and submit to [ProviderRoster@empowerarkansas.com](mailto:ProviderRoster@empowerarkansas.com)

**Return Completed Application To**:

Email: [Empower.Network@empowerarkansas.com](mailto:Empower.Network@empowerarkansas.com)

|  |  |
| --- | --- |
| **Legal Information** | |
| Legal Name: | Tax ID: |
| D/B/A: | AR Medicaid #: |
| National Provider ID (NPI): |  |

|  |  |
| --- | --- |
| **Capacity on Certificate of Compliance** | |
| Residential Facility-Capacity (# of residents): | Adult Day Care (# of participants): |

|  |  |
| --- | --- |
| **Malpractice Insurance Information (if applicable)** | |
| Carrier Name: | Insured Amount: |
| Effective Date: | Expiration Date: |
| Policy # | Aggregate Cover Amount: |

|  |  |
| --- | --- |
| **General Liability Insurance Information** | |
| Carrier Name: | Insured Amount: |
| Effective Date: | Expiration Date: |
| Policy # | Aggregate Cover Amount: |

**Attestation of Facility**

Please complete the below attestation including signing and dating.

By signing below the representative of “Agency” attests the below for all employees and contracted provider(s).

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned authorized representative of Agency, on behalf of Agency, attest that the following has been completed on each caregiver prior to allowing them to care for any Empower members:

* Conducted Criminal Background Check;
* Reviewed State Child Maltreatment Registry;
* Reviewed State Adult Maltreatment Registry;
* Successfully Passed Drug Screening; and
* Confirmed Active Driver’s License (if applicable).

Agency also attest the truth and accuracy of the below disclosure questions (please circle applicable answer):

|  |  |
| --- | --- |
| 1. Has your organization’s license ever been restricted, conditioned, suspended or terminated? | YES NO |
| 1. In the last 12 months has the organization lost its licensure, certification, or accreditation? | YES NO |
| 1. Does the organization have any limitations on its State or Federal standings, Medicare, Medicaid, or any other medical reimbursement plan. | YES NO |
| 1. Has the organization ever been or are they currently excluded from participation with Medicare or any other federally funded healthcare program? | YES NO |
| 1. Has the organizations professional liability coverage ever been restricted, limited, or denied for any reason? | YES NO |
| 1. Has the organization ever been disciplined for a violation of ethical standards by a professional organization? | YES NO |
| 1. Has the organization ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? | YES NO |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Person Completing Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HCBS Provider Attestation**

Please confirm that the organization ensures that all providers:

|  |  |
| --- | --- |
| Meet all licensing requirements necessary by the state of Arkansas, | YES NO |
| Have not been terminated, suspended, debarred or had their participation in any federal or state health care programs in any way, shape or form, including, but not limited to, voluntary withdrawal from any program for any period of time, | YES NO |
| Have not had a controlled drug license withdrawn, | YES NO |
| Have not been convicted of any criminal offenses, including but not limited to Medicaid or Medicare fraud, any unlawful dispensing of controlled or illegal substances, | YES NO |
| Have not been in connection with or convicted of any form of negligence or abuse of patients, |  |
| Nor any connection or conviction of any fraud, theft, breach of fiduciary responsibility, or any other form of financial misconduct on behalf of any patients in the last year. | YES NO |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Person Completing Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_