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|  | **COMMUNITY AND EMPLOYMENT SUPPORT WAIVER PROVIDER****CERTIFICATION APPLICATION** |

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| **1.** | Name of Organization: |       |
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| **2.** | Name of Authorized Representative: |       |
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| **3.** | Title of Authorized Representative: |       |
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| **4.** | Business Mailing Address: |       |
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| **5.** | Physical Address of Service Location: |       |
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| **6.** | Telephone: |       | Fax: |       |
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| **7.** | E-Mail: |       |
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| **8.** | Federal Employer Identification Number (EIN): |       |
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| **9.** | Date of Application: |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | (DD/MM/YY) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **10.** | Dates of Yearly Operation: |       | To: |       |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | (DD/MM/YY) |  |  |  | (DD/MM/YY) |  |  |  |
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| **11.** | Board Information (if applicable): |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Name** |  | **Address** |  | **Date of Term** |
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| **12.** | Services to be offered: |
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| [ ]  | Adaptive Equipment |  |  |
| [ ]  | Community Transition |  |  |
| [ ]  | Consultation |  |  |
| [ ]  | Crisis Intervention |  |  |
| [ ]  | Environmental Modifications |  |  |
| [ ]  | Respite |  |  |
| [ ]  | Specialized Medical Supplies |  |  |
| [ ]  | Supplemental Support |  |  |
| [ ]  | Supported Employment |  |  |
| [ ]  | Supportive Living |  |  |
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| **13.** | The following items shall be attached to this application: |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **A.** | Articles of Incorporation |
| **B.** | By-Laws |
| **C.** | Policies and Procedures |
| **D.** | Staff Development Curriculum |
| **E.** | Program Description |
| **F.** | Copy of Notification of Assignment of Federal EIN |
| **G.** | Original Adult Central Registry Check Results for Authorized Representative |
| **H.** | Original Child Central Registry Check Results for Authorized Representative |
| **I.** | DDS Determination Letter for Authorized Representative's State Criminal Background Check |
| **J.** | DDS Determination Letter regarding Authorized Representative's Federal Criminal Background Check |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Failure to provide any of the referenced documents may result in denial of the application. |
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| **14.** | Counties to be Served: Indicate Statewide or in a specific County or Counties. |
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| [ ]  Statewide |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ]  Arkansas | [ ]  Craighead | [ ]  Howard | [ ]  Miller | [ ]  Randolph |
| [ ]  Ashley | [ ]  Crawford | [ ]  Independence | [ ]  Mississippi | [ ]  Saline |
| [ ]  Baxter | [ ]  Crittenden | [ ]  Izard | [ ]  Monroe | [ ]  Scott |
| [ ]  Benton | [ ]  Cross | [ ]  Jackson | [ ]  Montgomery | [ ]  Searcy |
| [ ]  Boone | [ ]  Dallas | [ ]  Jefferson | [ ]  Nevada | [ ]  Sebastian |
| [ ]  Bradley | [ ]  Desha | [ ]  Johnson | [ ]  Newton | [ ]  Sevier |
| [ ]  Calhoun | [ ]  Drew | [ ]  Lafayette | [ ]  Ouachita | [ ]  Sharp |
| [ ]  Carroll | [ ]  Faulkner | [ ]  Lawrence | [ ]  Perry | [ ]  St. Francis |
| [ ]  Chicot | [ ]  Franklin | [ ]  Lee | [ ]  Phillips | [ ]  Stone |
| [ ]  Clark | [ ]  Fulton | [ ]  Lincoln | [ ]  Pike | [ ]  Union |
| [ ]  Clay | [ ]  Garland | [ ]  Little River | [ ]  Poinsett | [ ]  Van Buren |
| [ ]  Cleburne | [ ]  Grant | [ ]  Logan | [ ]  Polk | [ ]  Washington |
| [ ]  Cleveland | [ ]  Greene | [ ]  Lonoke | [ ]  Pope | [ ]  White |
| [ ]  Columbia | [ ]  Hempstead | [ ]  Madison | [ ]  Prairie | [ ]  Woodruff |
| [ ]  Conway | [ ]  Hot Spring | [ ]  Marion | [ ]  Pulaski | [ ]  Yell |
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| Arkansas Code Annotated §§20-48-201 et.seq. provides for the inspection and certification oforganizations providing services for people with developmental disabilities.I affirm that the composition of the Board meets the requirements set forth by Arkansas CodeAnnotated §§20-48-705 et.seq.I affirm that I have read, understand, and agree to comply with the DDS Agreement outlining MinimumStandards for PASSE HCBS Providers of Waiver Services. |
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| **Signature of Authorized Representative** |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Name of Authorized Representative (Print)** |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Title** |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Date** |  |  |  |  |  |  |  |  |  |  |  |  |
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**Instructions for the Application for Community and**

**Employment Supports Waiver Provider Certification**

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| --- | --- |
| **1.** | Full legal name of the organization seeking certification. |
|  |  |
| **2.** | Full legal name of the person designated as the Authorized Representative of the Organization. |
|  |  |
| **3.** | Authorized Representatives title within the organization. |
|  |  |
| **4.** | Mailing address for the Organization. |
|  |  |
| **5.** | Physical address, if different from the business address. |
|  |  |
| **6.** | Telephone number and fax number for the organization applying for certification. |
|  |  |
| **7.** | E-mail address for the Authorized Representative. |
|  |  |
| **8.** | Federal Employer Identification Number (EIN) assigned by IRS. |
|  |  |
| **9.** | The date the application is submitted to DDS. |
|  |  |
| **10.** | Services must be provided throughout the year. |
|  |  |
| **11.** | If applicable, current board members' names, addresses and beginning and end date for eachmember's term on the board. |
|  |  |
| **12.** | Mark service or services the organization intends to provide to consumers. |
|  |  |
| **13.** | The following items must be attached to the application: |
|  |  |
|  |  | **A.** | Articles of Incorporation. |
|  |  |  |  |
|  |  | **B.** | By-Laws. |
|  |  |  |  |
|  |  | **C.** | Policies and Procedures for the organization developed in accordance with the CES Waiver Standards to include: |
|  |  |  |  |  |  |
|  |  |  |  | **1.** | Board of Directors ***(CES 102.A)*** | **15.** | Individual Rights ***(CES 401) (Waiver Document G.2.a.ii)*** |
|  |  |  |  | **2.** | Board Meeting Schedule ***(CES 102.G)*** |
|  |  |  |  | **3.** | Nepotism ***(CES 103)*** | **16.** | Confidential Billing, Utilization, Clinical, Administrative and Service Related Information, Operation of Internet Based Services ***(CES 402.B)*** |
|  |  |  |  | **4.** | Conflict of Interest ***(CES 103.1)*** |
|  |  |  |  | **5.** | Board Training ***(CES 109)*** |
|  |  |  |  | **6.** | Eligibility Criteria, Readmission, Transition, Discharge ***(CES 111)*** |
|  |  |  |  | **17.** | Centralized Files, Staff access to Records ***(CES 402.D)*** |
|  |  |  |  | **7.** | Board Financial Oversight ***(CES 112)*** |
|  |  |  |  | **8.** | Personnel ***(CES 201)*** | **18.** | Grievance Policy ***(CES 403, 403.B)*** |
|  |  |  |  | **9.** | Pre-employment, Random and after Accidents Drug Screening ***(CES 201.3, 602.A.7, 802.A.7, 802.B.3, 1402.A.7, 1604 and 1802.A.7)*** | **19.** | Consumer Health Related Issues ***(CES 404A & B)*** |
|  |  |  |  |
|  |  |  |  | **20.** | Protection of Consumer Financial Interests ***(CES 405A)*** |
|  |  |  |  |
|  |  |  |  | **10.** | Staff’s name appears on either the Child or Adult Maltreatment Registry ***(202.B.2.a and (301.1.B.1)*** | **21.** | Incident Reporting, Including Follow-up ***(CES 406.C)*** |
|  |  |  |  |
|  |  |  |  | **22.** | Positive Programming, Non-Pervasive ***(CES 407.A)*** |
|  |  |  |  | **11.** | Staff Recruitment and Retention ***(CES 204)*** |
|  |  |  |  | **23.** | Positive Programming, Pervasive ***(CES 408.B)*** |
|  |  |  |  | **12.** | Access to Staff Files ***(CES 205.B)*** |
|  |  |  |  | **13.** | Student, Interns, Volunteers and Trainees ***(CES 207)*** | **24.** | Emergency Basis Intervention ***(CES 409.1)*** |
|  |  |  |  |
|  |  |  |  | **14.** | Staff Training Professional and Administrative Staff and Managerial Staff ***(CES 300.1, 301.4, 302, 802.D.2)*** | **25.** | Maltreatment and Corporal Punishment ***(CES 410.1) (Waiver Document G.2.a.i)*** |
|  |  |  |  |
|  |  |  |  | **26.** | Agency Intake ***(CES 502)*** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **D.** | Curriculum for staff development in accordance with the CES Waiver Standards. |
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|  |  | **E.** | Program description to include: the organization's mission statement; description of the services to be provided; and the admission, transition, discharge and exit criteria of consumers. |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **F.** | Copy of the notification of assignment of Federal EIN. |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **G.** | Original Adult Abuse Registry Check results for the Authorized Representative. Authorized Representative must complete form APS-0001 (\*) and submit it to the Adult Protective Services. |
|  |  |  |  | (\*) <https://humanservices.arkansas.gov/wp-content/uploads/APS-0001.doc> |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **H.** | Original Child Abuse Registry Check results for the Authorized Representative. Authorized Representative must complete an online Central Registry Request form (\*\*) and upload it to the Child Maltreatment Central Registry (\*\*\*). |
|  |  |  |  | (\*\*) <https://ardhs.formstack.com/forms/dcfs_central_registry_request_v2> |
|  |  |  |  | (\*\*\*) <https://ardhs.quickbase.com/db/bqq7fmaad?a=nwr&nexturl> |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **I.** | Copy of DDS Determination Letter for the Authorized Representative's AR State Criminal Background check. The Authorized Representative must complete for DDS-5088 (\*\*\*\*). For "Type of Provider" mark "Other: New provider Applicant.” |
|  |  |  | (\*\*\*\*) <https://humanservices.arkansas.gov/wp-content/uploads/State_5088.pdf> |
|  |  |  |  |
|  |  |  |  | **1.** | If the authorized Representative has not lived in Arkansas continuously for the fiveyears prior to the date of application, proceed to J. |
|  |  |  |  |  |  |
|  |  | **J.** | Copy of DDS Determination Letter for the Authorized Representative's FBI CriminalBackground check. Authorized Representative must complete for DDS-5088 (\*\*\*\*\*). For "Type of Provider" mark "Other: New Provider Applicant." |
|  |  |  | (\*\*\*\*\*) <https://humanservices.arkansas.gov/wp-content/uploads/FBI_5088.pdf> |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | **1.** | An FBI check is not required if the Authorized Representative has lived in Arkansasfor more than five years prior to the date of application. Verification can beestablished by submitting one of the following: |
|  |  |  |  |  |  | **1.** | employment records;  | **5.** | house payment records;  |
|  |  |  |  |  |  | **2.** | payroll check stubs;  | **6.** | utilities bills or;  |
|  |  |  |  |  |  | **3.** | tax records;  | **7.** | school records |
|  |  |  |  |  |  | **4.** | rent payment records;  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **14.** | Indicate whether the organization will offer services statewide or in a specific County orCounties.  |
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| Return the completed application and all requested documents to: |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | DHS St. Francis County C/O Lynn Davenport 1200 East Broadway Ave. P.O. Box 899 Forrest City, AR 72336-0899 Phone: 870-261-6668  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |