Division of Provider Services and Quality Assurance

State Licensure and CHOW

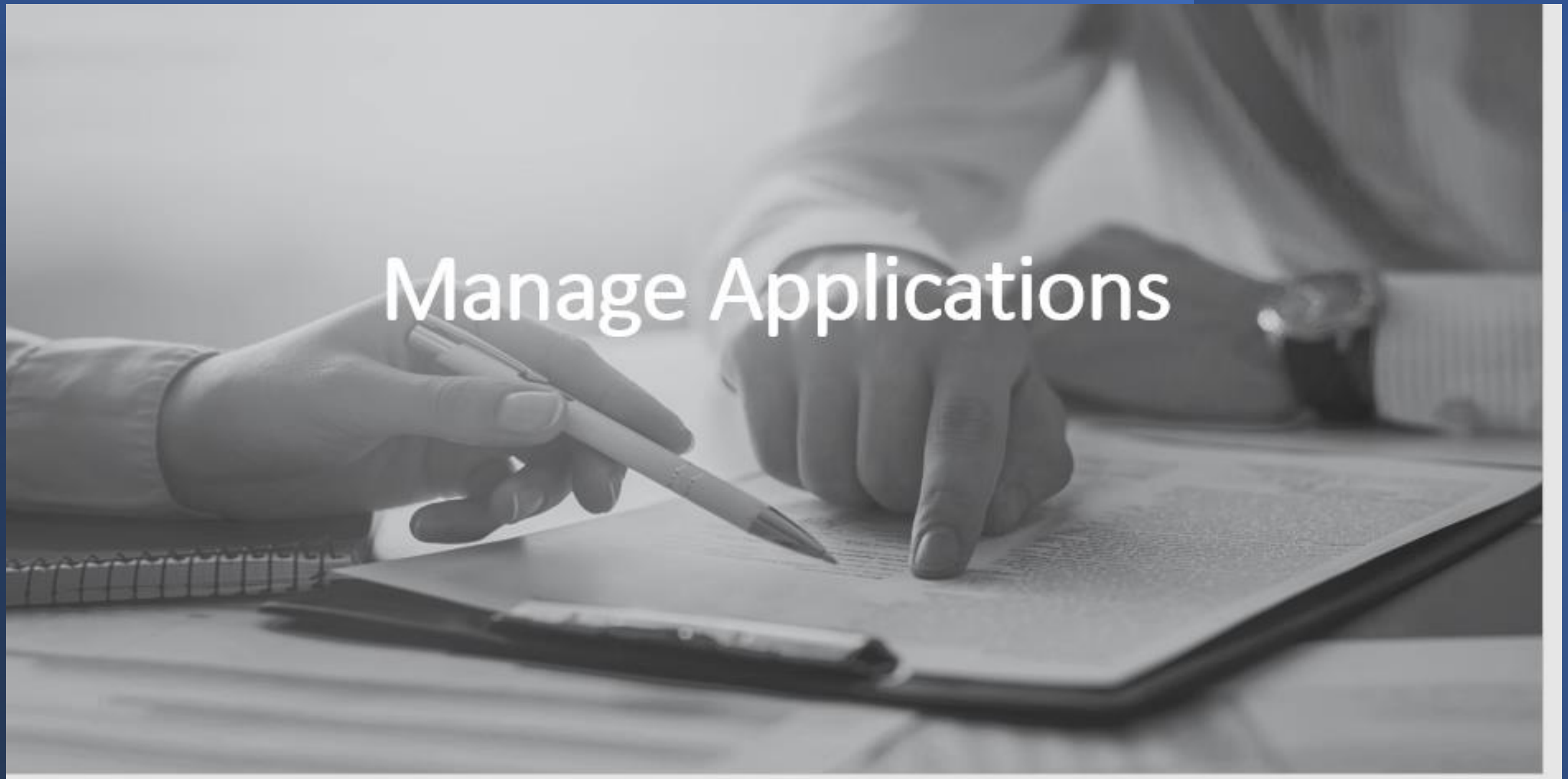
Enterprise Licensing Solution (ELS)Provider Training

ELS Log In and Getting Started

- Login with Username and Password
  - If you have issues logging in,

  click the [Click here] next to **Forgot you Password**

- Under Long Term Care Licensing, click Get Started (this button will change to Manage once you begin an application).


Manage Applications

My Applications/Start New Application

- Click Get Started in the Manage Applications tile.
  - The My Applications page is for any applications you begin or have completed previously.
    - No facility currently has an application so there is nothing here.
  - Click Start New Application
  - Select the Facility type that you are listed as:
    - This is a dropdown menu with all multiple facility options
  - This is the walkthrough of a Nursing Facility (NF)

Manage Facilities and New Applications

- Click Get Started on the Manage Facilities
  - Once you have an application approved by OLTC, you'll be able to manage the facility

- Click View to view the Facility information
  - You can review all your information here and add any additional information and upload documentation.

Related Links and Change of Ownership (CHOW)

- Click Related Links
- Click Submit Change of Information Request
  - Click Owner Information
  - Click Add New
    - You can enter Information of the Previous Operator, Information of New Operator

Back to Applications

New Application:
Nursing Facilities (NF)

- Facility Details
- Facility Address and Contact Information
- Management Information
- Licensure Information
- Ownership of Business
- Officers/Members
- Board of Directors
- Ownership of Building
- Change of Operational Control
- Owner Information
- Service Information
- Inspections
- Additional Information
- Documentation
- Review
- Payment Summary
- Sign & Submit

Facility Information

*Mandatory field

*Facility Name

*Facility IRS Number

DBA Name

Related Facilities
Yes No

Proposed Open Date
MM/DD/YYYY

Medicaid Provider Number

*Vendor #

*Previously Licensed in Arkansas
Yes No

Licensed but No Residents

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- Board of Directors
- Ownership of Building
- Change of Operational Control
- Owner Information
- Service Information
- Inspections
- Additional Information
- Documentation
- Review
- Payment Summary
- Sign & Submit

Facility Address and Contact Information

*Mandatory field

*Address

Address 2

*City

*State: AR

*Zip Code

County: Select an Option

*Out of State: Yes / No

Out of State County

*Phone

Phone Ext

Directions to Facility

Fax

Other(Phone)

*Facility Email Address

Facility Website

*Facility Contact First Name

*Facility Contact Last Name

*Facility Contact Title

*Facility Contact Email Address

Additional Services Provided: Select an Option

Mailing Address

*Mandatory field

Same as Physical Address?

*Address

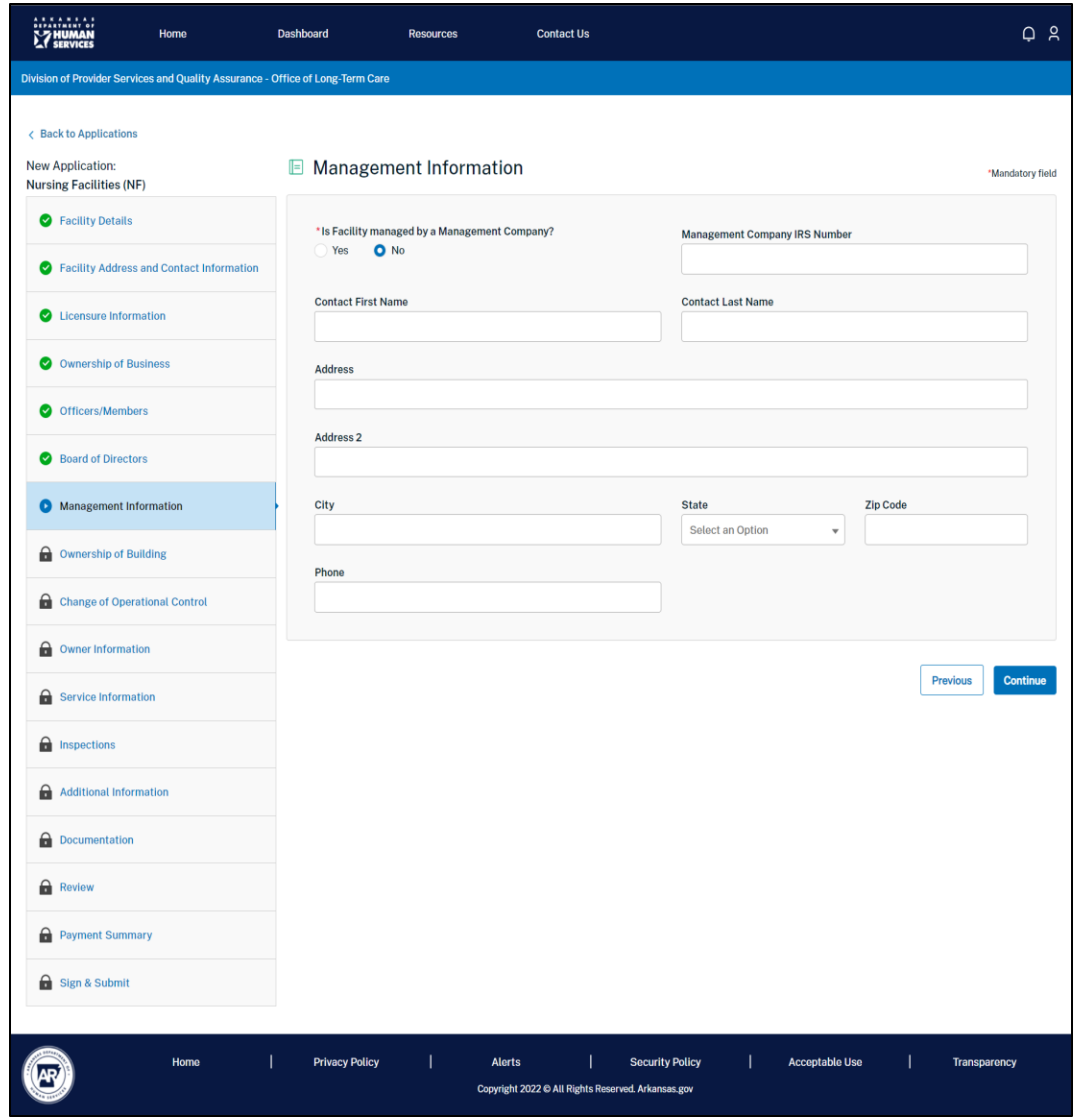
Address 2

*City

*State: AR

*Zip Code

Previous | Continue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Owner Information
Service Information
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Sign & Submit
Management Information
*Mandatory field
*Is Facility managed by a Management Company?
Yes
No
Management Company IRS Number
Contact First Name
Contact Last Name
Address
Address 2
City
State
Select an Option
Zip Code
Phone
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New Application:
Skilled Nursing Facilities/Nursing Facilities

- Facility/Provider Information
- Facility Address and Contact Information
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- Licensure Information
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- Change of Operational Control
- Owner Information
- Service Information
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- Additional Information
- Documentation

Licensure Information

*Mandatory field

Permit Approval Number

Date of Issue
MM/DD/YYYY

***Total number of Beds/Slots requested**
Complete this field.

Classification Types (To be documented during Change of Information or Renewal application process)
- [ ] Change of Ownership
- [ ] Decrease in Bed Capacity
- [ ] Increase in Bed Capacity
- [ ] Replacement
- [ ] Not Applicable

- [ ] Letter Requesting Bed Change Received

Increased/Decreased Beds to

Explain increase in licensed bed request

Medicaid Bed

Medicare Bed

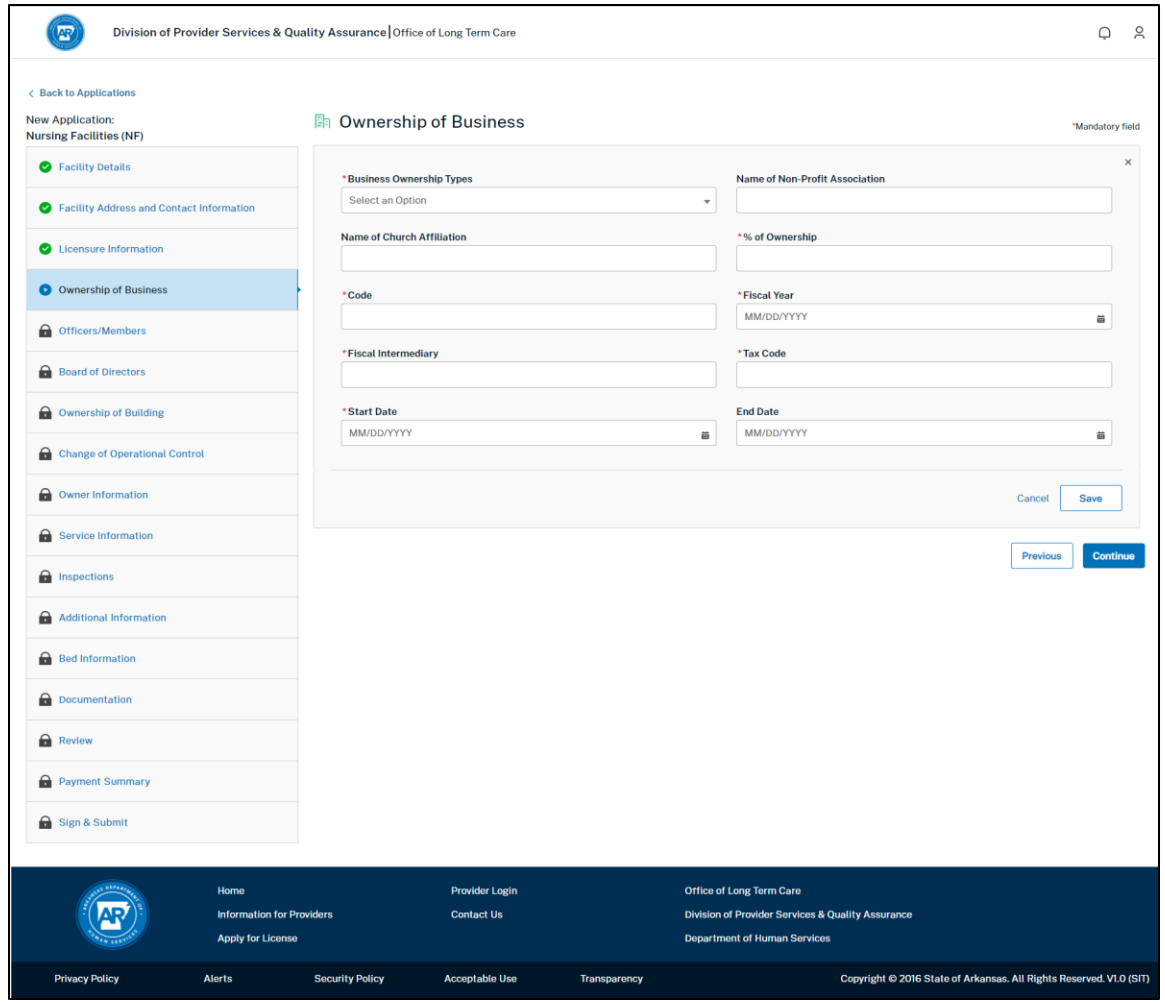
Medicaid/MedicareBed

Private Beds

Home Style Beds

Alzheimer Beds

Previous Continue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Bed Information
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Sign & Submit
Ownership of Business
*Mandatory field
*Business Ownership Types
Select an Option
Name of Non-Profit Association
Name of Church Affiliation
*% of Ownership
*Code
*Fiscal Year
MM/DD/YYYY
*Fiscal Intermediary
*Tax Code
*Start Date
MM/DD/YYYY
End Date
MM/DD/YYYY
Cancel
Save
Previous
Continue
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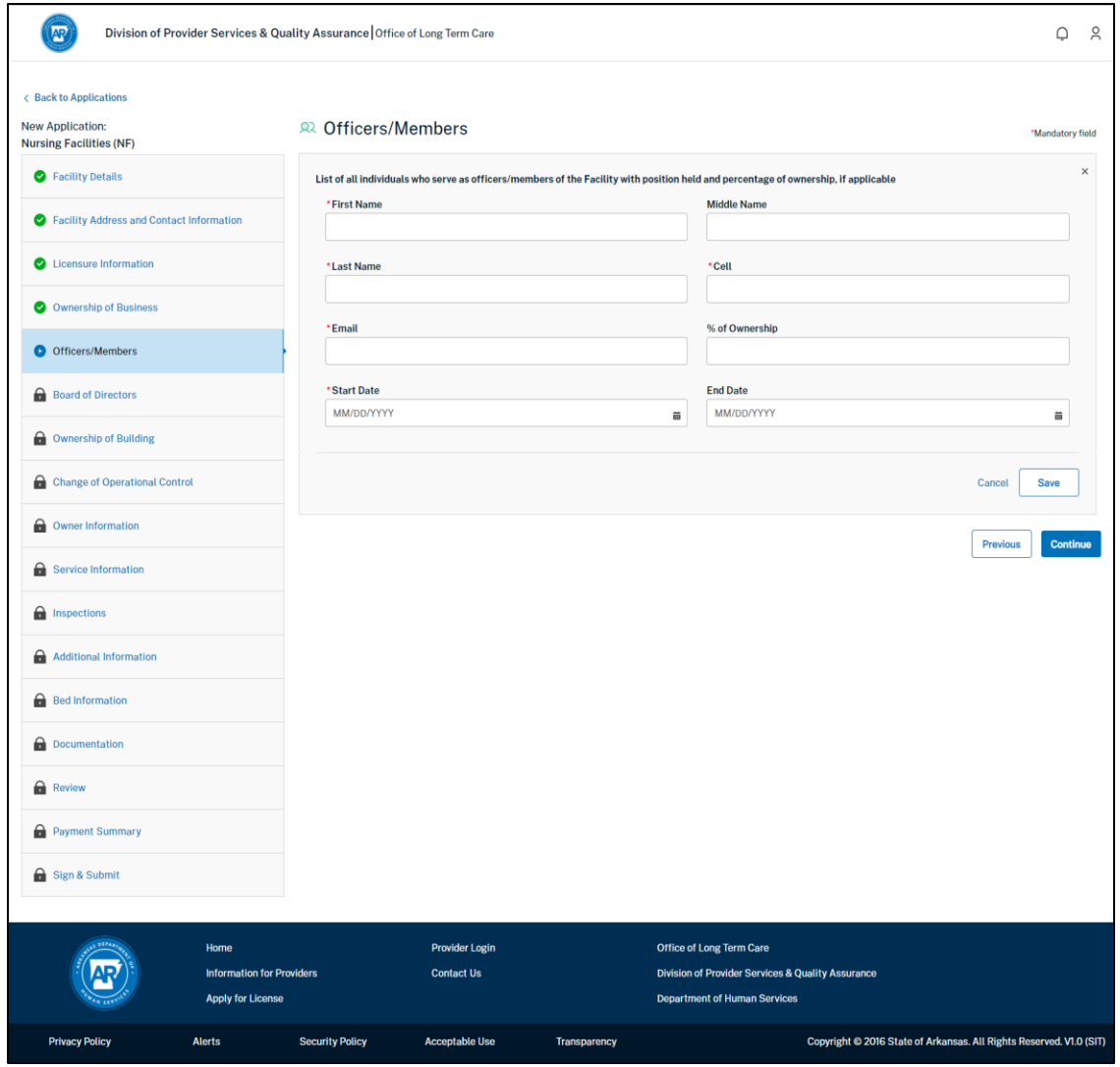
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Sign & Submit
Officers/Members
*Mandatory field
List of all individuals who serve as officers/members of the Facility with position held and percentage of ownership, if applicable
*First Name
Middle Name
*Last Name
*Cell
*Email
% of Ownership
*Start Date
End Date
MM/DD/YYYY
MM/DD/YYYY
Cancel
Save
Previous
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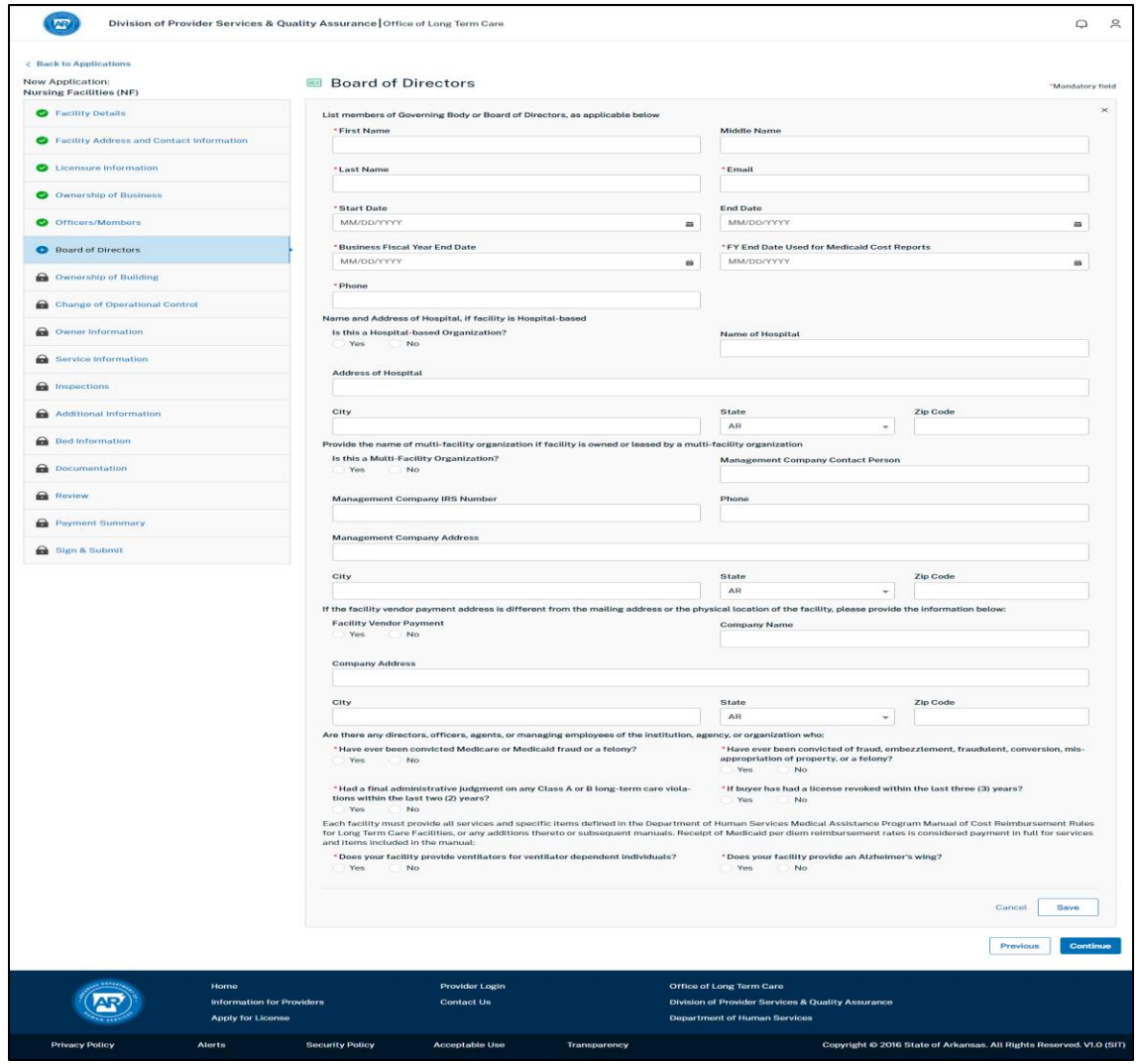
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Service Information
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Additional Information
Bed Information
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Payment Summary
Sign & Submit
Board of Directors
*Mandatory field
List members of Governing Body or Board of Directors, as applicable below
*First Name
Middle Name
*Last Name
*Email
*Start Date
MM/DD/YYYY
End Date
MM/DD/YYYY
*Business Fiscal Year End Date
MM/DD/YYYY
*FY End Date Used for Medicaid Cost Reports
MM/DD/YYYY
*Phone
Name and Address of Hospital, if facility is Hospital-based
Is this a Hospital-based Organization?
Yes
No
Name of Hospital
Address of Hospital
City
State
AR
Zip Code
Provide the name of multi-facility organization if facility is owned or leased by a multi-facility organization
Is this a Multi-Facility Organization?
Yes
No
Management Company Contact Person
Management Company IRS Number
Phone
Management Company Address
City
State
AR
Zip Code
If the facility vendor payment address is different from the mailing address or the physical location of the facility, please provide the information below:
Facility Vendor Payment
Yes
No
Company Name
Company Address
City
State
AR
Zip Code
Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who:
*Have ever been convicted Medicare or Medicaid fraud or a felony?
Yes
No
*Have ever been convicted of fraud, embezztement, fraudulent, conversion, mis-appropriation of property, or a felony?
Yes
No
*Had a final administrative judgment on any Class A or B long-term care viola-tions within the last two (2) years?
Yes
No
*If buyer has had a license revoked within the last three (3) years?
Yes
No
Each facility must provide all services and specific items defined in the Department of Human Services Medical Assistance Program Manual of Cost Reimbursement Rules for Long Term Care Facilities, or any additions thereto or subsequent manuals. Receipt of Medicaid per diem reimbursement rates is considered payment in full for services and items included in the manual:
*Does your facility provide ventilators for ventilator dependent individuals?
Yes
No
*Does your facility provide an Alzheimer's wing?
Yes
No
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Save
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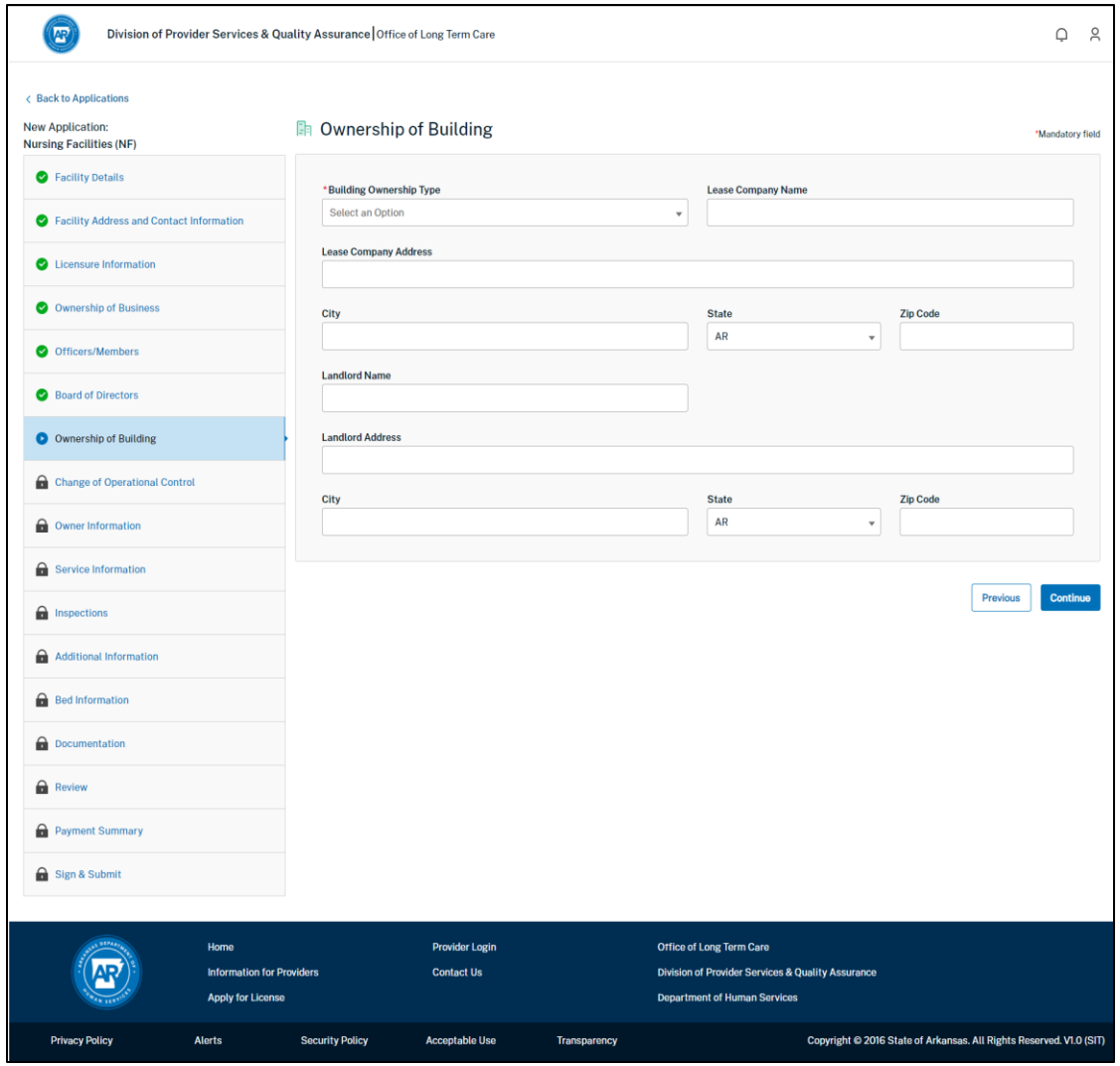
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Ownership of Building
*Mandatory field
*Building Ownership Type
Select an Option
Lease Company Name
Lease Company Address
City
State
AR
Zip Code
Landlord Name
Landlord Address
City
State
AR
Zip Code
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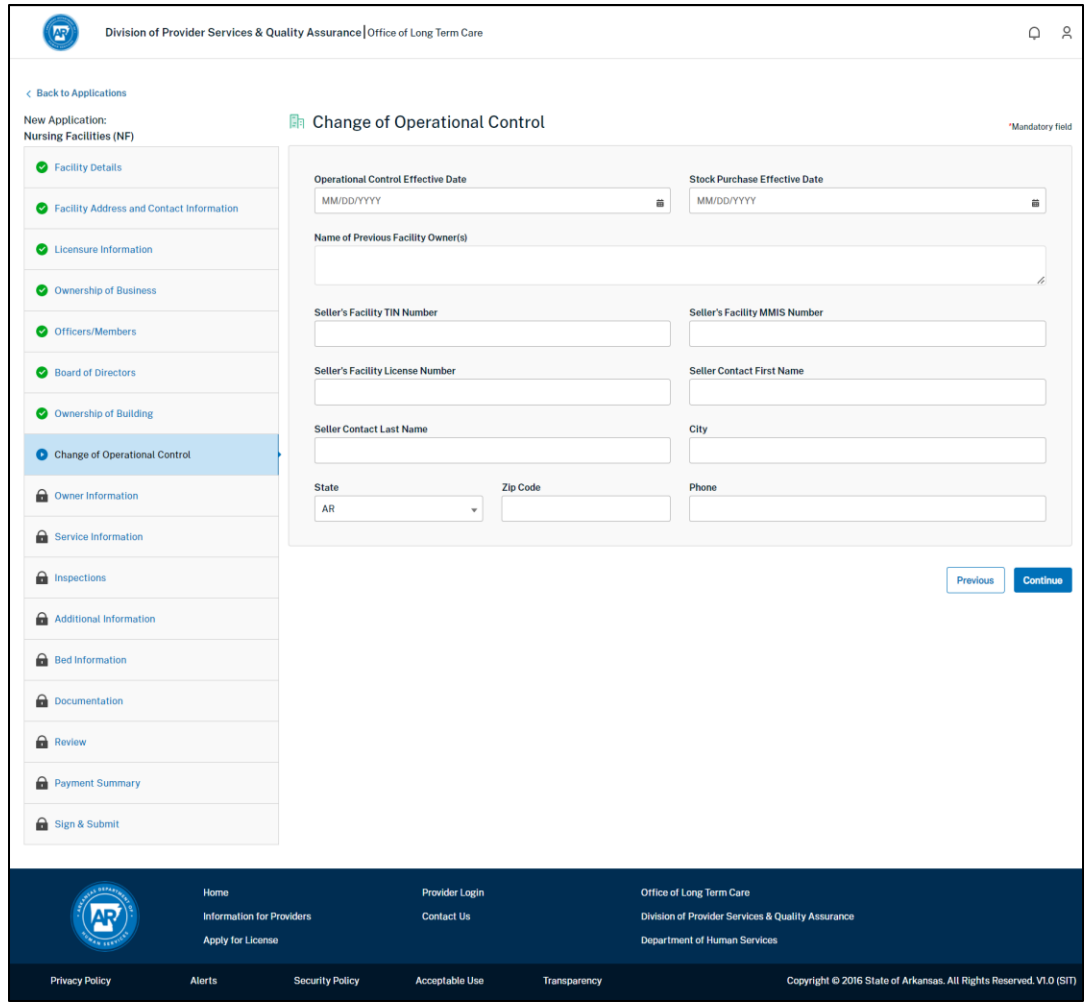
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Change of Operational Control
*Mandatory field
Operational Control Effective Date
MM/DD/YYYY
Stock Purchase Effective Date
MM/DD/YYYY
Name of Previous Facility Owner(s)
Seller's Facility TIN Number
Seller's Facility MMIS Number
Seller's Facility License Number
Seller Contact First Name
Seller Contact Last Name
City
State
AR
Zip Code
Phone
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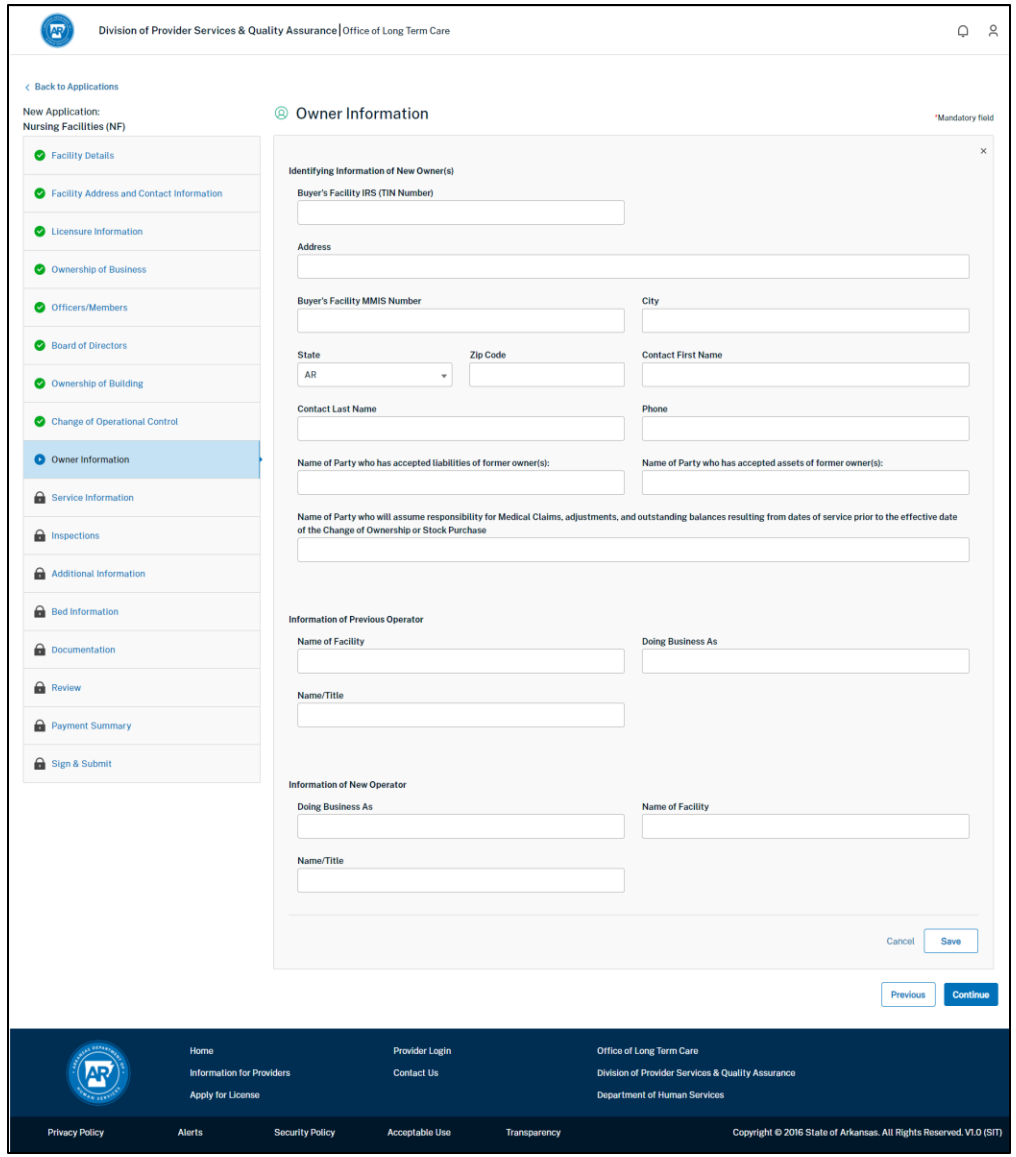
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Owner Information
*Mandatory field
Identifying Information of New Owner(s)
Buyer's Facility IRS (TIN Number)
Address
Buyer's Facility MMIS Number
City
State
AR
Zip Code
Contact First Name
Contact Last Name
Phone
Name of Party who has accepted liabilities of former owner(s):
Name of Party who has accepted assets of former owner(s):
Name of Party who will assume responsibility for Medical Claims, adjustments, and outstanding balances resulting from dates of service prior to the effective date of the Change of Ownership or Stock Purchase
Information of Previous Operator
Name of Facility
Doing Business As
Name/Title
Information of New Operator
Doing Business As
Name of Facility
Name/Title
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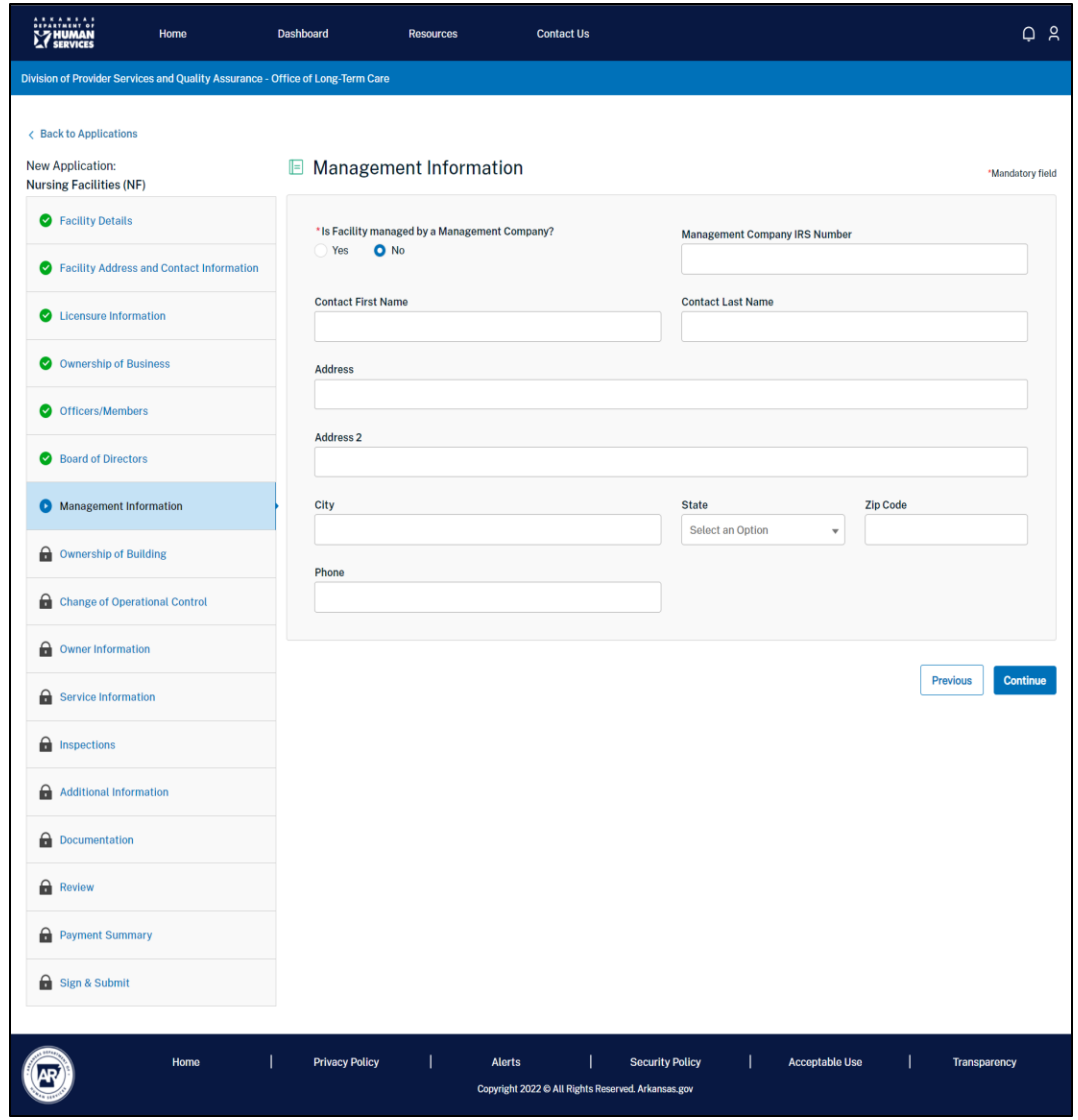
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Management Information
*Mandatory field
*Is Facility managed by a Management Company?
Yes
No
Management Company IRS Number
Contact First Name
Contact Last Name
Address
Address 2
City
State
Select an Option
Zip Code
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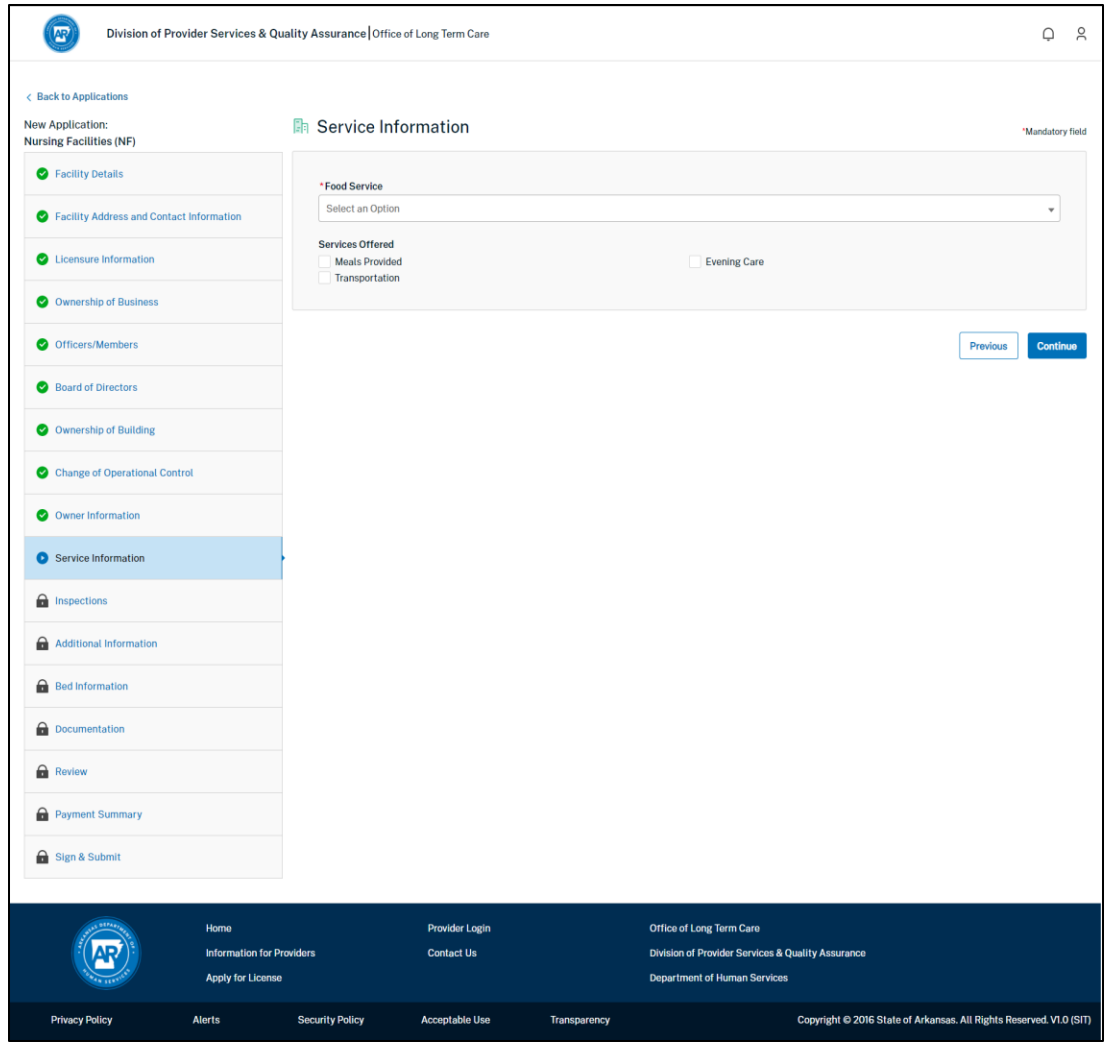
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*Mandatory field
*Food Service
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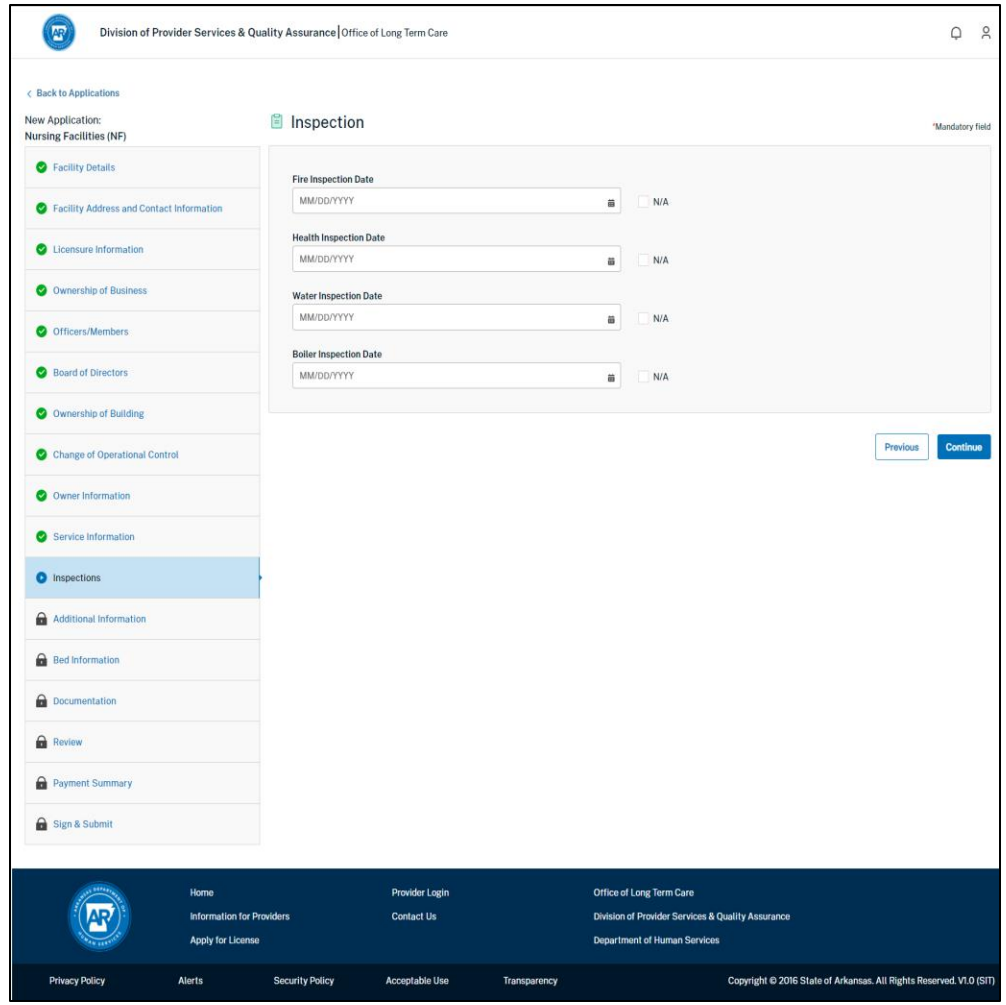
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Fire Inspection Date
MM/DD/YYYY
N/A
Health Inspection Date
MM/DD/YYYY
N/A
Water Inspection Date
MM/DD/YYYY
N/A
Boiler Inspection Date
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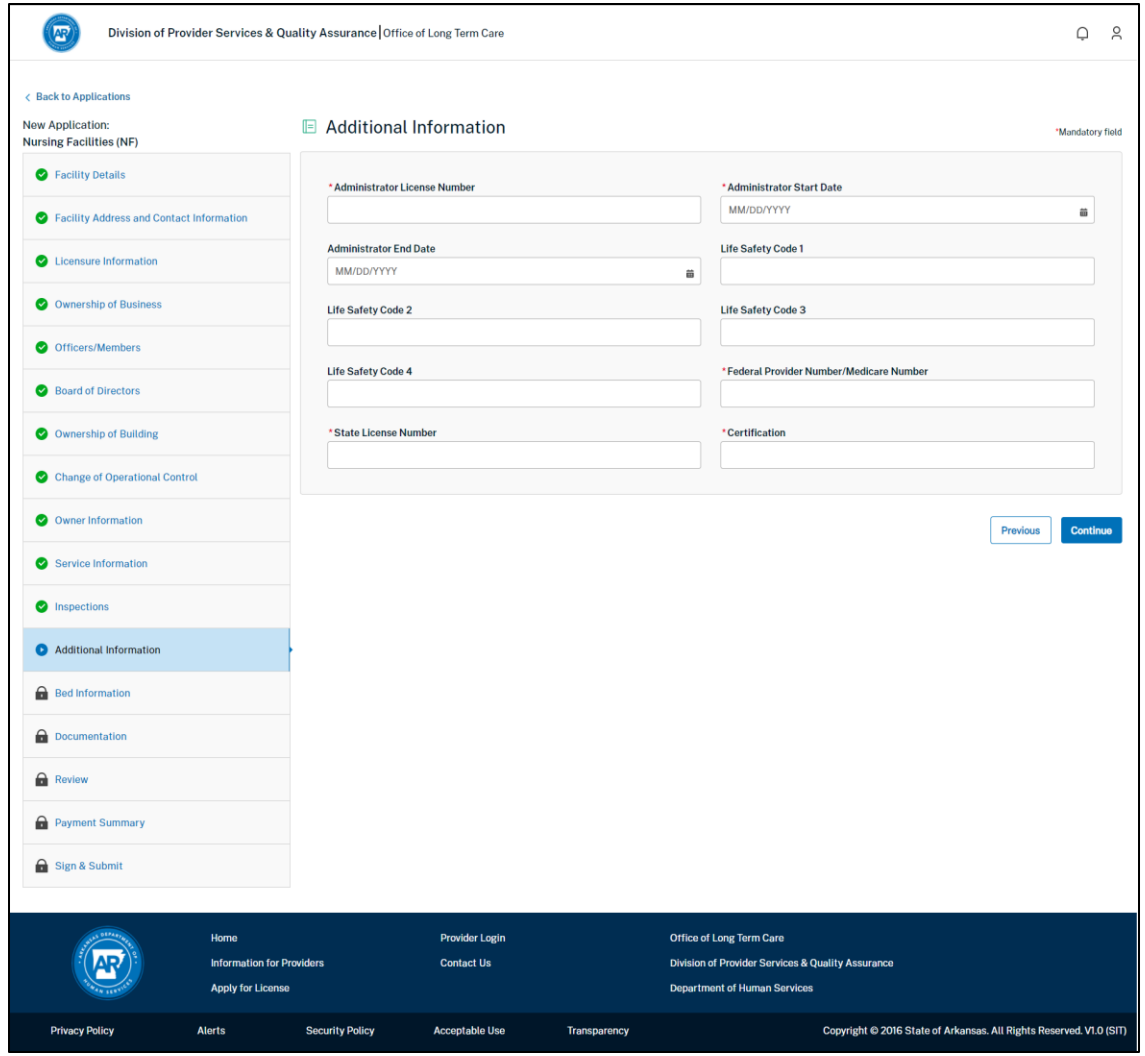
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*Mandatory field
*Administrator License Number
*Administrator Start Date
MM/DD/YYYY
Administrator End Date
MM/DD/YYYY
Life Safety Code 1
Life Safety Code 2
Life Safety Code 3
Life Safety Code 4
*Federal Provider Number/Medicare Number
*State License Number
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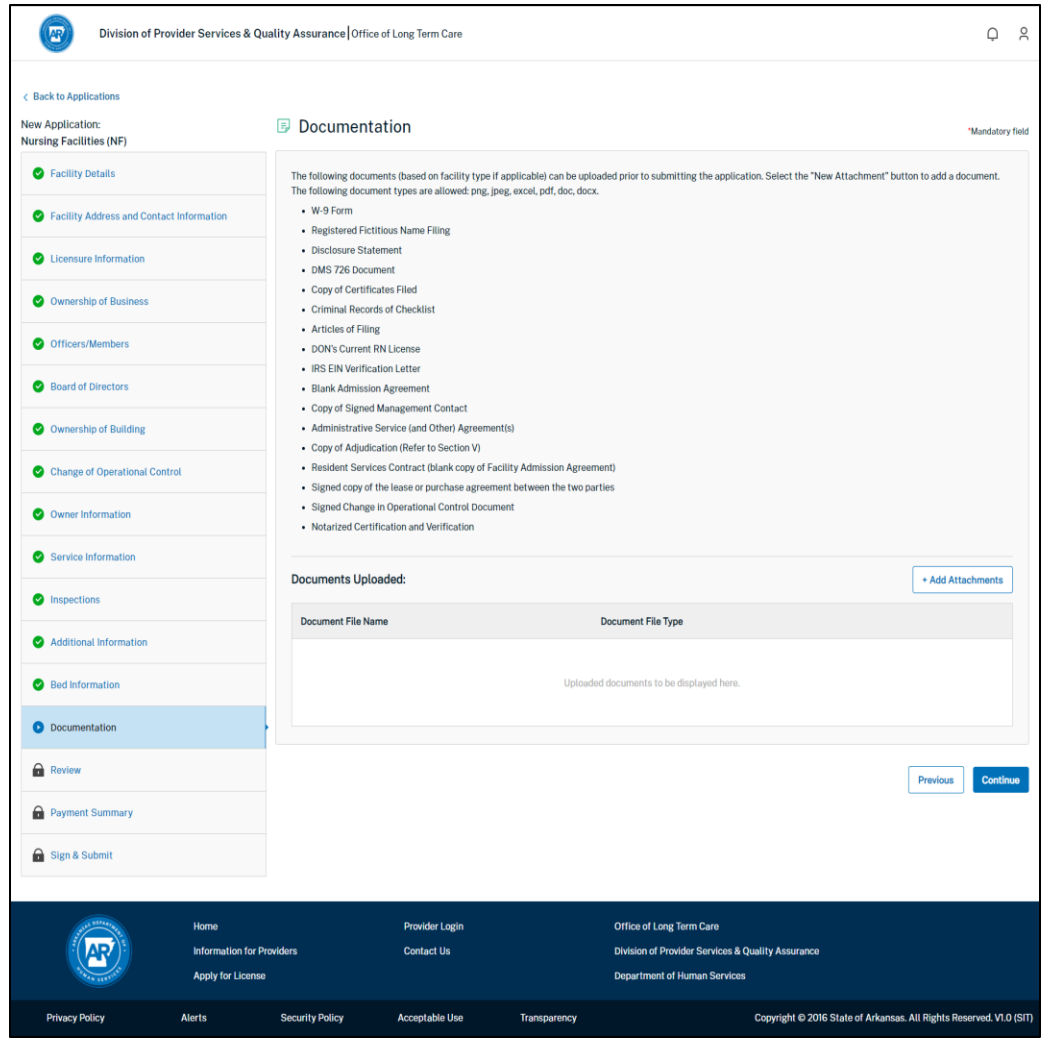
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Documentation
*Mandatory field
The following documents (based on facility type if applicable) can be uploaded prior to submitting the application. Select the "New Attachment" button to add a document.
The following document types are allowed: png, jpeg, excel, pdf, doc, docx.
W-9 Form
Registered Fictitious Name Filing
Disclosure Statement
DMS 726 Document
Copy of Certificates Filed
Criminal Records of Checklist
Articles of Filing
DON's Current RN License
IRS EIN Verification Letter
Blank Admission Agreement
Copy of Signed Management Contact
Administrative Service (and Other) Agreement(s)
Copy of Adjudication (Refer to Section V)
Resident Services Contract (blank copy of Facility Admission Agreement)
Signed copy of the lease or purchase agreement between the two parties
Signed Change in Operational Control Document
Notarized Certification and Verification
Documents Uploaded:
+ Add Attachments
Document File Name
Document File Type
Uploaded documents to be displayed here.
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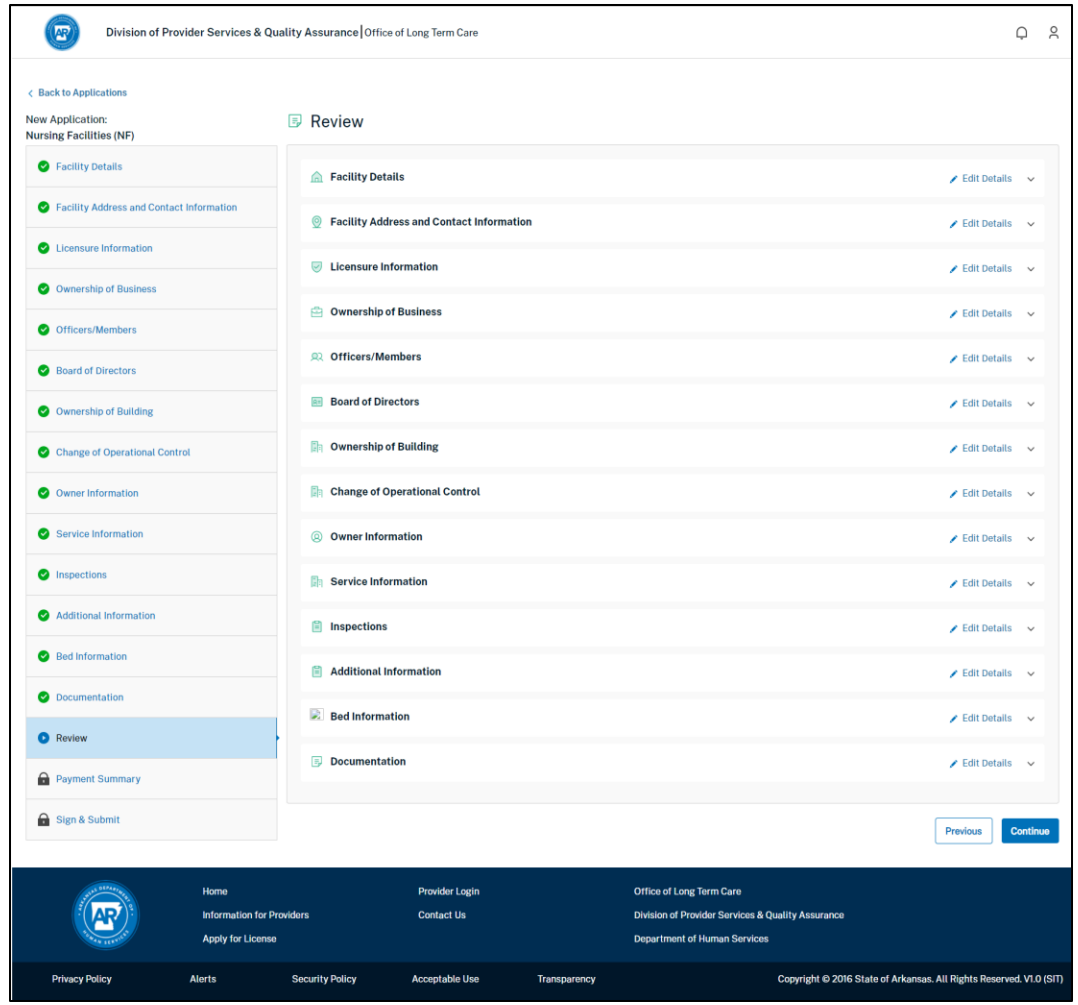
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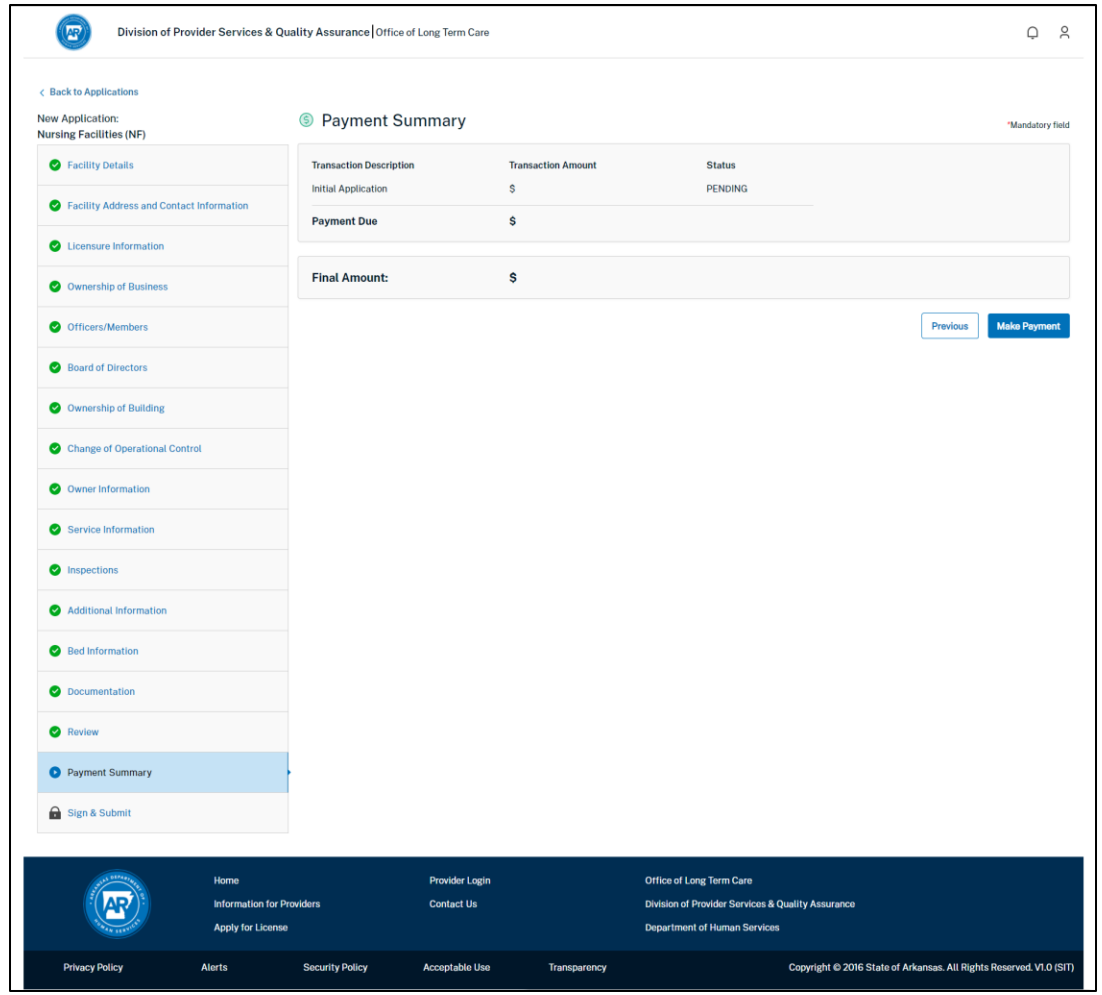
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Payment Summary
Sign & Submit
Payment Summary
*Mandatory field
Transaction Description
Transaction Amount
Status
Initial Application
$
PENDING
Payment Due
$
Final Amount:
$
Previous
Make Payment
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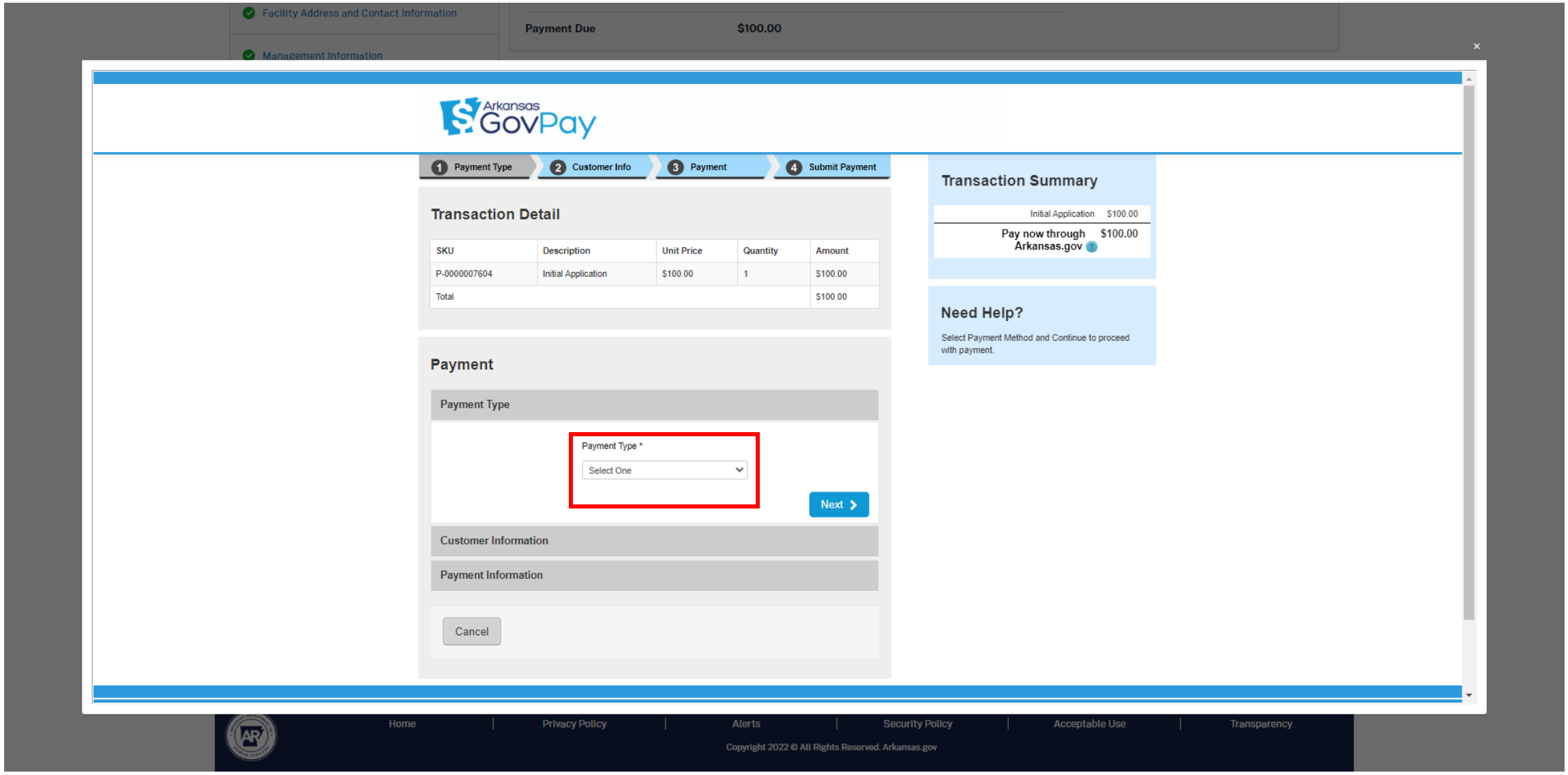
Facility Address and Contact Information
Management Information
Payment Due $100.00
Arkansas GovPay
1 Payment Type
2 Customer Info
3 Payment
4 Submit Payment
Transaction Detail
SKU | Description | Unit Price | Quantity | Amount
P-0000007604 | Initial Application | $100.00 | 1 | $100.00
Total $100.00
Payment
Payment Type
Payment Type *
Select One
Next
Customer Information
Payment Information
Cancel
Transaction Summary
Initial Application $100.00
Pay now through Arkansas.gov $100.00
Need Help?
Select Payment Method and Continue to proceed with payment.
Home
Privacy Policy
Alerts
Security Policy
Acceptable Use
Transparency
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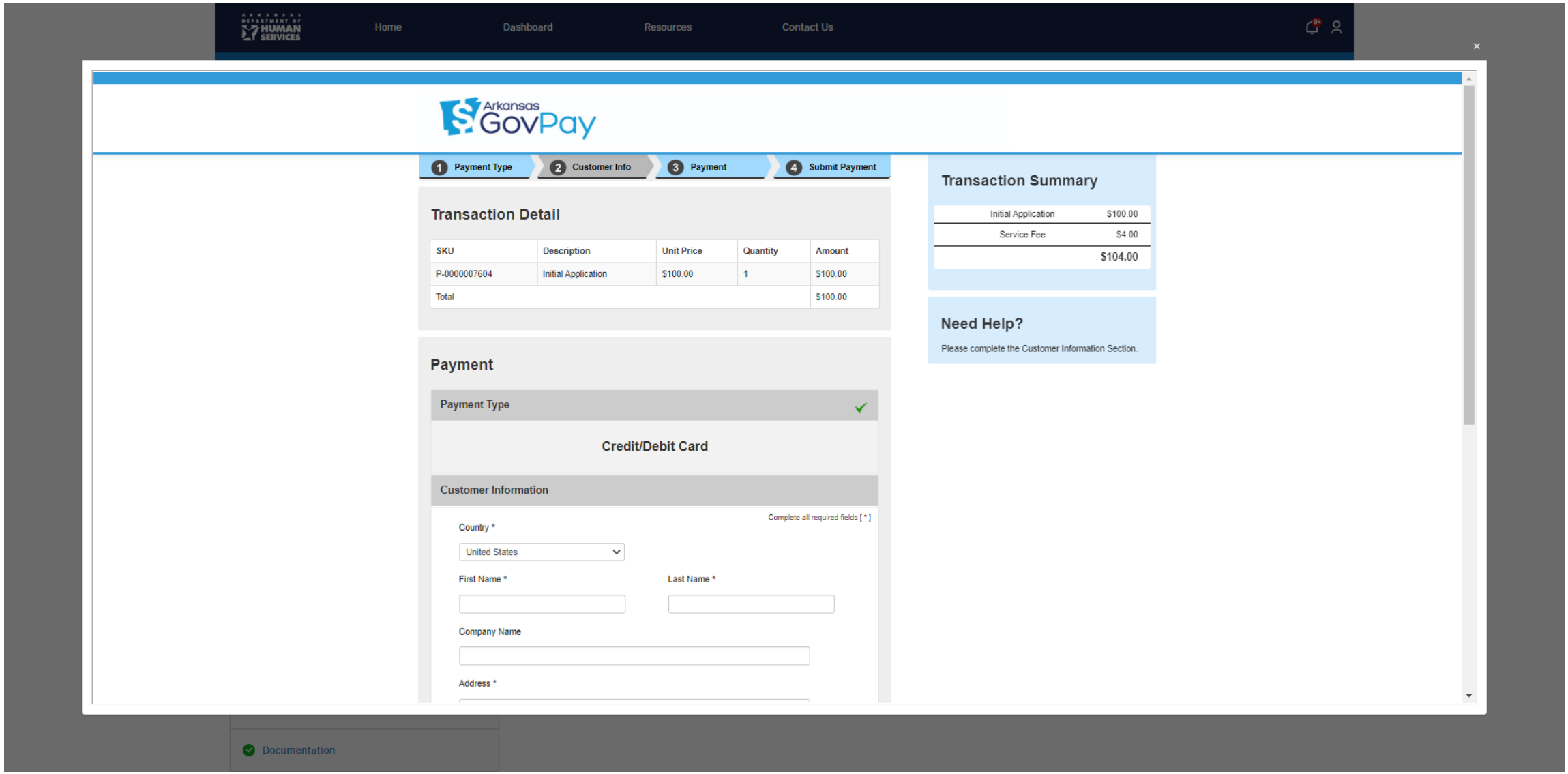
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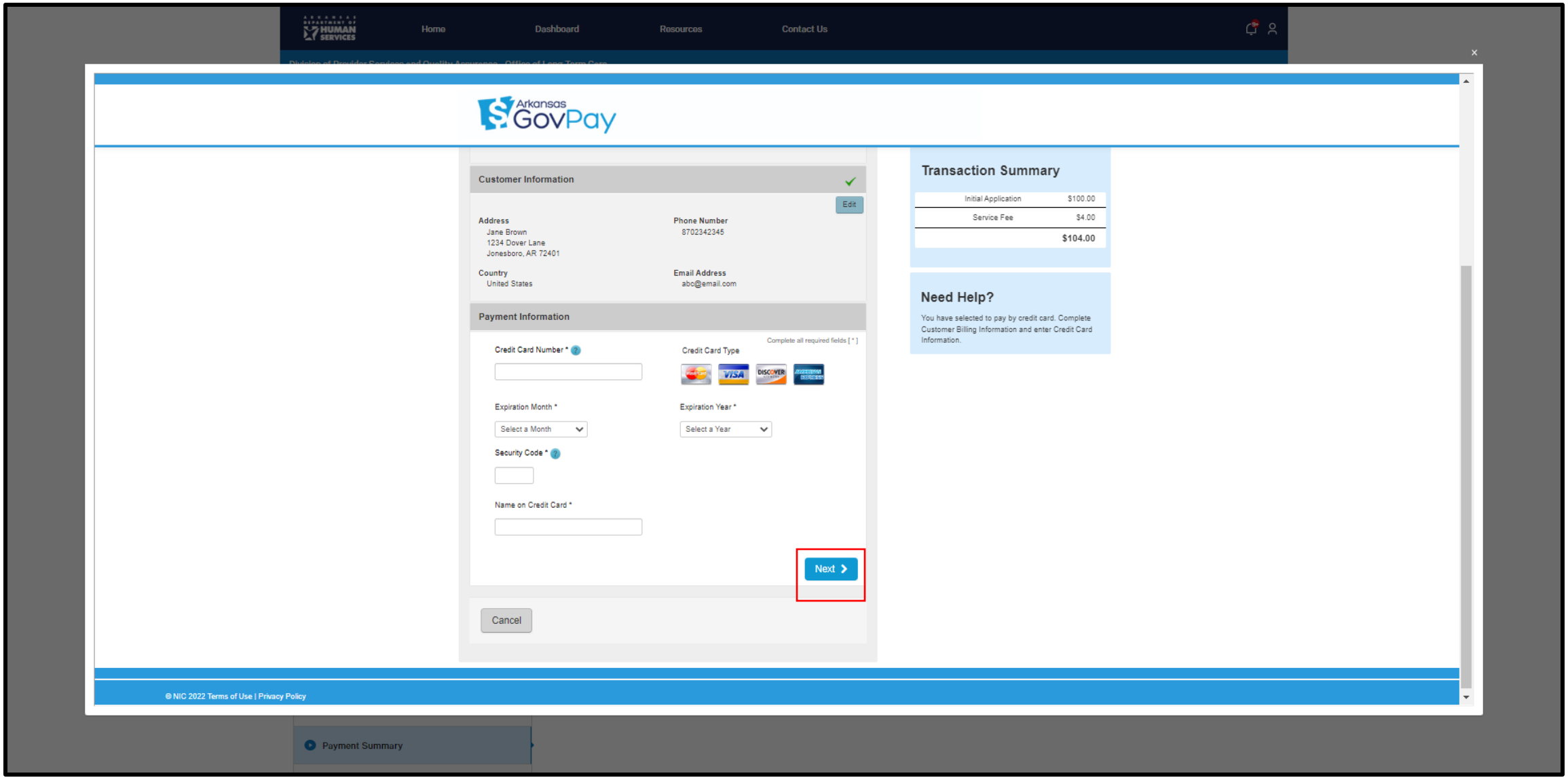
Contact Us
Arkansas GovPay
1 Payment Type
2 Customer Info
3 Payment
4 Submit Payment
Transaction Detail
SKU
Description
Unit Price
Quantity
Amount
P-0000007604
Initial Application
$100.00
1
$100.00
Total
$100.00
Payment
Payment Type
Credit/Debit Card
Customer Information
Complete all required fields [*]
Country *
United States
First Name *
Last Name *
Company Name
Address *
Transaction Summary
Initial Application $100.00
Service Fee $4.00
$104.00
Need Help?
Please complete the Customer Information Section.
Documentation


Home
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Arkansas GovPay
Customer Information
Edit
Address
Jane Brown
1234 Dover Lane
Jonesboro, AR 72401
Phone Number
8702342345
Country
United States
Email Address
abc@email.com
Payment Information
Complete all required fields [*]
Credit Card Number *
Credit Card Type
Expiration Month *
Select a Month
Expiration Year *
Select a Year
Security Code *
Name on Credit Card *
Next
Cancel
Transaction Summary
Initial Application $100.00
Service Fee $4.00
$104.00
Need Help?
You have selected to pay by credit card. Complete Customer Billing Information and enter Credit Card Information.
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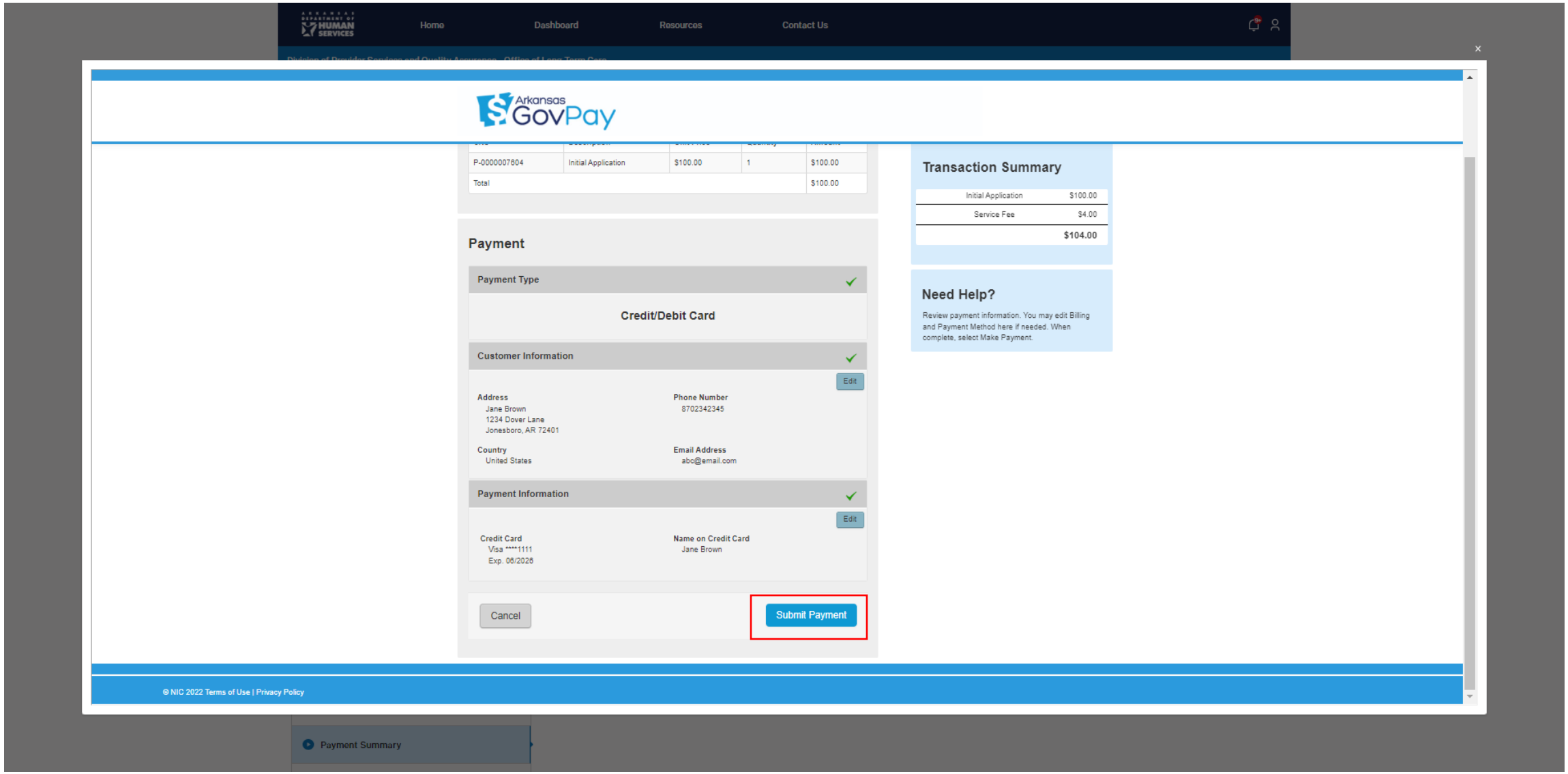
Payment Summary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P-0000007604
Initial Application
$100.00
1
$100.00
Total
$100.00
Payment
Payment Type
Credit/Debit Card
Customer Information
Edit
Address
Jane Brown
1234 Dover Lane
Jonesboro, AR 72401
Phone Number
8702342345
Country
United States
Email Address
abc@email.com
Payment Information
Edit
Credit Card
Visa ****1111
Exp. 06/2026
Name on Credit Card
Jane Brown
Cancel
Submit Payment
Transaction Summary
Initial Application $100.00
Service Fee $4.00
$104.00
Need Help?
Review payment information. You may edit Billing and Payment Method here if needed. When complete, select Make Payment.
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Payment Summary

Back to Applications

New Application:
Skilled Nursing Facilities/Nursing Facilities

Facility/Provider Information
Facility Address and Contact Information
Management Information
Licensure Information
Ownership of Business
Officers/Members
Board of Directors
Ownership of Building
Change of Operational Control
Owner Information
Service Information
Inspections
Additional Information
Documentation
Review
Payment Summary

Payment Summary

*Mandatory field

Payment Sucessfully Recieved

Facility Number 00047564	Transaction Number 64917148
Transaction Date/Time 8/8/2022, 12:04:29 PM	Total Fee Amount $104.00

Print Receipt

Previous Continue