ARKANSAS DEPARTMENT OF HUMAN SERVICES

ALTERNATIVE COMMUNITY SERVICES WAIVER PROVIDER CERTIFICATION APPLICATION

1. Name of Organization: _____
2. Name of Authorized Representative: _____
3. Title of Authorized Representative: _____
4. Business Mailing Address: _____
5. Physical Address of Service Location: _____
6. Telephone: _____ Fax: _____
7. E-Mail: _____
8. Federal Employer Identification Number (EIN): _____
9. Date of Application: _____ (DD/MM/YY)
10. Dates of Yearly Operation: _____ (DD/MM/YY) To: _____ (DD/MM/YY)

11. Board Information (if applicable):

Name	Address	Date of Term

12. Services to be offered:

	Organized Health Care Delivery System Services
☐ Adaptive Equipment	☐ Adaptive Equipment
☐ Case Management	☐ Case Management
☐ Community Transition	☐ Community Transition
☐ Consultation	☐ Consultation
☐ Crisis Intervention	☐ Crisis Intervention
☐ Environmental Modifications	☐ Environmental Modifications
☐ Respite	☐ Respite
☐ Specialized Medical Supplies	☐ Specialized Medical Supplies
☐ Supplemental Support	☐ Supplemental Support
☐ Supported Employment	☐ Supported Employment
☐ Supportive Living	☐ Supportive Living

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.

14. Counties to be Served:

☐ Statewide **or**

☐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 Springs	☐Marion	☐Pulaski	☐Yell

Arkansas Code Annotated §§20-48-201 et.seq. provides for the inspection and certification of organizations providing services for people with developmental disabilities. DDS Standards for ACS Waiver Services have been promulgated in accordance with Arkansas Code Annotated §§25-15-201 et.seq.

I affirm that the composition of the Board meets the requirements set forth by DDS Standards for Waiver Services 102.A.2 and Arkansas Code Annotated §§20-48-705 et.seq.

I affirm that I have read, understand and agree to comply with the DDS Standards for ACS Waiver Services.

_____

Signature of Authorized Representative

_____

Name of Authorized Representative (Print)

_____

Title

_____

Date