PROVIDER TYPE PROFILE

PROVIDER TYPE	40	ATTENDANT CARE * (PAGE 1 OF 2) **COMPANIES ONLY**
REIMBURSE-MENT TYPE	02	FEE FOR SERVICE EFFECTIVE 10-01-88

CATEGORIES OF SERVICE			**LICENSE/CERTIFICATION**
MANDATORY	28	ATTENDANT CARE	
MANDATORY			
OPTIONAL	23	HOMEMAKER	
OPTIONAL	26	RESPITE CARE	
OPTIONAL	31	NON EMERGENCY TRANSPORTATION	PROOF OF VEHICLE INSURANCE NOTE: COS 31 UNAVAILABLE FOR 12 MONTHS AFTER APPROVAL.
OPTIONAL	39	PERSONAL CARE	
OPTIONAL	43	SPECIALIZED SERVICES	(EFFECTIVE 10/1/03)
OPTIONAL	47	MENTAL HEALTH SERVICES	(EFFECTIVE 04/01/08)
OPTIONAL			
OPTIONAL			
OPTIONAL			
OPTIONAL			

SPECIAL INSTRUCTIONS: Companies are required to comply with training and recordkeeping standards for Direct Care Workers as outlined in the AHCCCS Medical Policy Manual, Chapter 1200, Section 1240-A. Documentation must be made available to AHCCCS and Contractors upon request.

As a part of the registration process the owner/provider is required to disclose each employees' name, social security number, employment begin date, employment end date (if applicable), and date of birth information using the 2nd page of this form. All staffing changes must be reported within 30 days.

In addition, the Non-Emergency Transportation category of service will be unavailable for Attendant Care providers for the first year after approval. Additionally, after the first year, this provider type will be permitted to provide a minimum of 70% or more Attendant Care services and can provide no more than 30% Non-Emergency Transportation Care. This requirement only applies to Fee For Service providers and does not apply to registered providers who are contracted with a Managed Care Organization.

Company Name_____ ID Number_____

Signature_____ Date_____

REVISED 6/01/2015

PROVIDER TYPE PROFILE

PROVIDER TYPE	40	ATTENDANT CARE * (PAGE 2 OF 2) **COMPANIES ONLY**
REIMBURSE-MENT TYPE	02	FEE FOR SERVICE EFFECTIVE 10/01/1988

List of Employees

(ALL FIELDS ARE MANDATORY)

Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)

Copy if additional pages are needed. REVISED 1/9/2015

This information is required in accordance with 42 CFR 455 Subparts B and E and State Medicaid Director Letters 08-003 & 09-001.

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