Department of Health and Human Services

NC DIVISION OF AGING AND ADULT SERVICES

Aging Resources Management System (ARMS)

FORMS INSTRUCTIONS

PROVIDER AGENCY INFORMATION DAAS-150

A. PURPOSE

Provider Agency information is collected each year and/or updated as needed in the ARMS system. This information must exist in ARMS before provider budgets or contract segments can be setup in ARMS and before service unit, consumer contributions, and non-unit reimbursement data, can process for reimbursement.

B. GENERAL INSTRUCTIONS

1. This form is completed for new aging service providers or Department of Social Services (DSS) providing services under Option B. The local service provider must have a contract with the AAA. This form is not applicable to subcontractors.

2. All **new** forms must be sent to the Division of Aging and Adult Services (DAAS). DAAS will enter the information in the ARMS system.

3. DSS should send the form to DAAS and maintain a copy for their files, if they are providing services under Option B.

C. SPECIFIC INSTRUCTIONS FOR EACH ITEM

1. TYPE OF INFORMATION: Indicate what action is being taken with this form. Check one item only. REQUIRED

   a. New - Check this item the first time this form is completed each contract year

   b. Change - Check this item when information which was previously submitted is being changed.

2. DATE: Enter the date the form is being completed. Enter a two (2) digit number to reflect the month and days. Precede one (1) digit months and days with a zero (0). Enter the four (4) digit year. REQUIRED

3. REGION: Enter the one (1) digit alpha or numeric character which identifies the region. REQUIRED

4. PROVIDER CODE: Leave the four (4) digit Provider Code field blank when submitting **new information**. The State ARMS Coordinator will assign a provider code. A provider code for a DSS will be identical to the county code with the region code preceding (example: A022). REQUIRED

5. CONTRACT YEAR: Enter the four (4) digit fiscal year. REQUIRED

6. AGENCY NAME: Enter the complete Agency Name. Spaces and dashes are allowed. If adequate spaces are not available, enter as much of the name as possible. Enter no more than one (1) letter per space. REQUIRED for new forms.

7. TELEPHONE: Enter the agency telephone number, include area code. REQUIRED
   EXTENSION: OPTIONAL
   FAX NUMBER: Enter the agency FAX number, include area code. OPTIONAL

8. AGENCY ADDRESS: Enter the Agency's mailing address. Spaces and dashes are allowed. If adequate spaces are not available, enter as much of the address as possible. Enter no more than one (1) letter per space. Address, City, State, and the first five (5) digits of the zip code are REQUIRED.

9. CONTACT PERSON(S): Enter the first and last name and title of an agency contact person to contact regarding the program and services. At least one contact person, title and a valid e-mail address REQUIRED.

10. TYPE AGENCY: Check the type of agency which is applicable (Non-Profit, Profit, Public, Minority). An agency cannot be Non-Profit and Profit, or Public and Profit, etc. But an agency can be Non-Profit and Minority or Profit and Minority. Those not applicable should be left blank. At least one agency type is REQUIRED.

11. TYPE SERVICES PROVIDED: Check all types of services provided by the agency which are funded by DAAS administered funds. If your agency provides supportive services only, do not complete the remainder of the form. All items can be checked as appropriate. At least one service type is REQUIRED.

12. NUMBER OF FACILITIES BY TYPE: The Number of Facilities by Type for providers of Congregate Nutrition ONLY. Indicate the number of facilities your agency operates by type. Those not applicable should be left blank. At least one (1) type must have a number greater than zero (0).

13. CONGREGATE - NUMBER OF DAYS SERVING: Indicate the number of days serving per-week. This is REQUIRED for providers of Congregate Nutrition.

14. SERVING MORE THAN ONE MEAL PER DAY: Indicate whether the agency serves more than one (1) meal per-day. Check YES if the agency habitually serves more than one (1) meal per-day and NO if it does not. This is REQUIRED for providers of Congregate Nutrition.

15. HOME DELIVERED MEALS - NUMBER OF DAYS DELIVERING: Indicate the number of days the agency normally provides Home Delivered Meals per-week. This is REQUIRED for providers of Home Delivered Meals.

16. DELIVERING MORE THAN ONE MEAL PER DAY: Indicate if more than one (1) Home Delivered Meal is delivered per day per person by checking YES or NO. This is REQUIRED for providers of Home Delivered Meals.