REGISTERED REPORTER OF WORK AND COMMUNITY ENGAGEMENT ACTIVITIES ACKNOWLEDGMENT FORM

Reporter Information

Reporter Name (*Last, First Middle*)	Relationship to Enrollee/Member	Broker or Agent NPN # *(If Applicable)* Organization or Employer
Reporter Address	Reporter Phone Number	Reporter E-mail Address

☐ **I certify that I have viewed ["Reporting Walkthrough" and "Linking Walkthrough"], a training program that provided information on my role and responsibilities as a Registered Reporter in the Arkansas Works Program.**

- As an authorized Registered Reporter, I am authorized to inspect and/or receive confidential health and work information for the limited purpose of reporting the Arkansas Works (AR Works) work and community engagement activities or exemptions for enrollees/members who have authorized me to enter their data into the portal at www.access.arkansas.gov. I understand that unless authorized by law, I cannot disclose personal information of any enrollee/member to third parties for purposes other than the preparation and reporting of the AR Works work and community engagement activities or exemptions to the DHS Medicaid Program. I understand that enrollees/members may withdraw their consent at any time, and are not required to use my services and I have not made any such representations to enrollees/members.
- I understand that upon receipt of the written revocation I am no longer authorized to access, inspect, and/or receive confidential health and work information concerning the above named enrollee/member or anyone included in the Medicaid file of the enrollee/member.
- I understand that I must electronically report the enrollee's/member's work and community engagement activities and exemptions through the online portal for any enrollees/members who have authorized my services with true, accurate, and correct information, and that I will provide it in accordance with the applicable laws and regulations. I understand that I will not be held responsible for accurately entering information that is provided to me by an enrollee/member that is inaccurate or false. I understand that I may cancel this arrangement with written notice to the enrollee/member and the Arkansas Department of Human Services.
- I acknowledge that the information reported through the portal represents a "claim" that will be presented to the Medicaid program as documentation submitted electronically to justify or help establish or determine what is to be paid for healthcare goods or services delivered to a Medicaid recipient. I understand that knowingly providing false or incomplete information could subject me to legal action, including but not limited to actions brought under the Medicaid False Claims Act or Ark. Code Ann. § 5-36-202 (Theft of Public Benefits).

____
Registered Reporter Signature

____
Date

*This form must be scanned and emailed to AWREPORTER@dhs.arkansas.gov and retained by the registered reporter.