INSTRUCTIONS FOR COMPLETING
THE ARKANSAS AMBULANCE ASSOCIATION
MEDICAID SUPPLEMENTAL PAYMENT PROGRAM SUPPORT AGREEMENT

Note: This contract is structured for one company or individual owning one or more agencies. If the agency is freestanding, then the "Participant" and the "Participating Provider" are the same. If the provider is owned by another company (alone or as part of a group of providers), then the "Participant" is the owners and the "Participating Providers" are the individual providers.

- Page 10:
  - Fill in name of company that owns the provider on the line labeled "PARTICIPANT." If there's only one provider, the Participant may be the same as the Participating Provider (see below).
  - Sign next to "By:"
  - Insert signer's name
  - Insert signer's title
  - Insert date signed

- Page 11 (Schedule I.9): List all providers owned by the "Participant" and put the Medicaid provider number next to each. Every Participating Provider listed in this Schedule will be a party to the Agreement.

- Page 12 (Exhibit II.3 Sections I-III): Complete bank account information in the blanks provided and describe any liens or other restrictions that would prevent the ArAA from drafting the account described. Complete one form for each Participating Provider listed on Schedule I.9.

- Page 12 (Exhibit II.3 Section IV): Do not fill in the date in the section labeled "Agreement"; the staff will compete this section.

- Page 13 (Exhibit II.3): Fill in your company name on the line labeled "PARTICIPANT" – This should match Page 10. Sign, print your name and list your title in the blanks provided.

- Page 14 (Exhibit III.1.E): Select whether you want to receive your payments from the ArAA as an EFT payment or paper check by initialing your selection; Complete the relevant information for your selection (either bank account information or

address for mailing of check). Complete one form for each Participating Provider listed on Schedule I.9.

- Page 15 (Exhibit V.3): Fill in your notice information in the blanks provided next to "If to Participant." If you would like notice provided to an additional party, fill in the notice information next to "With a copy to." Complete one form for each Participating Provider listed on Schedule I.9.