New Provider Workshop

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March 2020
Agenda

• Introduction – MMIS Outreach Team
• Getting Started as a New Provider
• Provider Enrollment Tools
• Who’s Who at Medicaid
• Billing Matters
• Healthcare Portal Features
• Training Tools and Resources
• Things to Know
• Contact Information
• Trainer led Portal Training
MMIS Outreach Team
MMIS Representative Services

AFMC’s MMIS outreach specialists are available to help Arkansas providers with questions about:

• Medicaid policy
• Billing requirements
• Claims processing

Our specialists are adept researchers, problem solvers and decision makers.
Eblast Sign-up

The following path can be used to sign up for the AFMC MMIS eblast:

- Navigate to the Arkansas Medicaid website (https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx)
- Under “What do you need?” choose the option for “Provider”
- Choose “Support” from the left side of the page
- Choose the first option for “AFMC MMIS eblast sign-up”
Eblast Sign-up Link

Sign-up for MMIS email updates

Name *

First

Last

Email *

Submit

Let’s Get Started

• Nine-digit provider ID and what it means
• National provider ID (NPI)
• Atypical providers (not needing an NPI)
• Additional things to know at the beginning
• Provider enrollment information
Provider Enrollment Information

- Instructions for how to complete your application (PDF, new window)
- Required Documents Finder (Excel, new window)
- Video instruction for how to complete your application (MP4, new window)
- Start your application now (HTML, new window)
Provider Enrollment Updates
Provider Re-validation on the Healthcare Portal
Who’s Who at Medicaid

- Division of Medical Services (DMS)
  https://humanservices.arkansas.gov/offices
- County offices (DCO)
  https://humanservices.arkansas.gov/offices/dhs-county-office-map
- AFMC www.afmc.org
  - MMIS Outreach Specialists 501-906-7566 (refer to map for extension #) www.afmc.org/mmis
  - ConnectCare 800-275-1131 www.seeyourdoc.org
  - Provider Relations Outreach specialists - email www.afmc.org/providerrelations
  - AFMC review department 479-649-8501
- eQHealth prior authorization and extension of benefits
  Ar.pr@eqhs or 888-660-3831
  877-HMS-0184
- Office of Medicaid Inspector General (OMIG) 855-527-6644
- Magellan Medicaid Administration Pharmacy Help Desk 800-424-7895, Option 2 for Prescribers
- DXC Technology 800-457-4454
- PASSE-DHS PASSE Provider Call Center 888-889-6451
- MCNA Dental 800-494-MCNA
- Delta Dental Smiles Customer Service 866-864-2499
DHS Division of Medical Services (DMS) – Administers Arkansas Medicaid

- DMS establishes policy for all Medicaid programs
- Provider reimbursement establishes reimbursement rates
- TPL validates third-party liability information
- Program development and quality assurance distributes Medicaid policy and monitors waiver programs
- Utilization review assists with claims and makes coverage determinations
- Medical assistance manages program communications plus dental and visual programs
- Pharmacy makes coverage determination and manages all drug-related issues
DHS County Offices

- Work directly with beneficiaries
- Determine eligibility, plan description and eligibility time frame
- Assist with primary care physician (PCP) selection
AFMC

- Arkansas’ leading health care quality improvement organization
- Serves as a liaison for Medicaid and providers, including primary care, specialty providers, PCMH-PT and hospitals
- Manages Medicaid quality improvement projects, including the Inpatient Quality Incentive (IQI) program
- Operates beneficiary service center, which handles complaints, Arkansas Works, transportation, etc.
- Provides utilization and quality review for various Medicaid programs
- Authorizes extensions of benefits
AFMC - MMIS Provider Outreach Specialists

• Provider outreach specialists handle billing that has been escalated from the Provider Assistance Center (PAC). They are also available to visit your office by appointment. **This can be done virtually or face-to-face.**

• You can find your provider outreach specialist at [www.afmc.org](http://www.afmc.org) or on the Medicaid website [https://medicaid.mmis.arkansas.gov](https://medicaid.mmis.arkansas.gov) under What do you need? Provider information> Support> AFMC Outreach Specialists

• You may contact your representative by calling **501-906-7566** and entering their extension (please refer to the map).

*Note: If you would like a one-on-one meeting to answer specific questions after this training, please contact your rep.*
AFMC ConnectCare Helpline

- Assigns and changes beneficiaries’ PCP
- Educates beneficiaries about Medicaid
- Emails confirmation notices, PCP lists and outreach materials to beneficiaries
- Processes PCP dismissals
- Coordinates with caseworkers to assign PCPs for foster children
- [www.seeyourdoc.org](http://www.seeyourdoc.org)
- 1-800-275-1131
AFMC – Provider Relations Outreach Specialists

• Provider relations outreach specialists are policy experts and educators who work with health care providers. They help practices navigate the Medicaid system and stay up-to-date on policy and procedures. During visits, the specialists will educate on state initiatives, provide educational tools to implement best practices and gather feedback for the state. Some of the current initiatives include:
  o Episodes of Care
  o Patient-centered Medical Home (PCMH)
  o PASSE
AFMC – Provider Relations Outreach Specialists

• You can find your provider relations outreach specialists map and provider packets with updated information at www.afmc.org/providerrelations.

• You can also visit the Medicaid website. Specialists are listed under Medicaid Managed Care Services (MMCS) outreach specialists (Provider > Support > AFMC Outreach Specialists > MMCS)
Provider Education Resources

- Webinar Power Point Trainings
- Pre Recorded EQSuite Training
- Forms & Downloads
- Register For A Webinar
Health Management Systems (HMS) – Third-party Recovery

Health management systems (HMS) provides services that identify third-party payment sources (such as commercial insurance and health plans, Medicare and TRICARE) and recovers public health plan expenditures when third-party liability exists.

https://hms.com

1-877-HMS-0184
OMIG detects schemes of fraud, curbs unacceptable practices, and improves quality of care as it relates to Medicaid fraud, waste and abuse. **Medicaid fraud can be reported by calling:**

- Arkansas Medicaid Inspector General's Hotline: 1-855-5AR-OMIG (1-855-527-6644), or
Magellan Medicaid Administration (MMA) processes Arkansas Medicaid pharmacy claims.

MMA performs the following functions:

- Claims processing
- Operations support for the pharmacy program
- Call center operations for providers and members
- Clinical consultation services
- Education and outreach for providers
DXC Technology – Fiscal Agent

- Provider enrollment
- Claims processing
- Remittance advice
- Provider Assistance Center (PAC)
- Electronic Data Interchange (EDI)
DXC Technology – Provider Assistance Center (PAC) and Electronic Data Interchange (EDI)

Your first point of contact for billing, claim status general questions and technical issues:

Monday through Friday  6 a.m. – 6 p.m.
Toll-free in Arkansas    800-457-4454
Local or out-of-state    501-376-2211
PASSE Contact Information

• Arkansas Total Care: 866-282-6280
• Empower Healthcare Solutions: 855-429-1028
• Summit Community Care: 844-462-0022
• DHS PASSE Provider Call Center
  o 888-889-6451
  o passe.provider.questions@dhs.arkansas.gov
Dental Contact Information

• Beneficiary dental coordinated care
  o Helpline: 800-322-5580
  o [https://afmc.org/individuals/arkansans-on-medicaid/connectcare-2/](https://afmc.org/individuals/arkansans-on-medicaid/connectcare-2/)

• MCNA Dental
  o 800-494-MCNA
  o contactus@mcna.net
Delta Dental Contact Information

• Matt Kelley (Northeast and Central districts)
  o 501-804-2915 or 501-992-1766
  o mkelley1@deltadentalar.com

• Whitney Palmer (Northwest and Central districts)
  o 501-607-3331 or 501-992-1750
  o wpalmer@deltadentalar.com

• Tondelayo Wayne (Southeast, Southwest, Central)
  o 501-607-3803 or 501-992-1748
  o twayne@deltadentalar.com
Billing Matters

• Importance of checking eligibility (see slide)
• Benefits plans (crosswalk helps determine coverage)
• Benefit limits (see slide)
• Timely filing guidelines (see slides)
• How to submit pseudo claims
• Adjustments

• Refunds
• Ways to submit claims
  o Portal (see slide)
  o PES (decommissioning)
  o Vendor
  o Paper
• Where/when to send paper claims (see slide)
Importance of Checking Eligibility

Coverage Details for Beneficiary ID: 4050221700 - PATTI PPFI from 1/1/2020 to 1/10/2020

<table>
<thead>
<tr>
<th>Benefit Details</th>
<th>Description</th>
<th>County</th>
<th>Effective Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>25-MCADD</td>
<td>Full Medicaid</td>
<td>654-PULABOT</td>
<td>01/01/2020</td>
<td>01/10/2020</td>
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<table>
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<th>Co-payments</th>
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</tbody>
</table>

Limit Details

Managed Care Assignment Details

Tier Level Details

Medicare/TPA

EPDOS Well Child Service Details

ARKERSI Screening

Adult Dental Service

Demographic Details

Print Preview
Tools to Determine Eligibility

• Benefit plan crosswalk
  • https://medicaid.mmis.arkansas.gov/Download/Provider/Insider/MMIS_BenefitPlans.pdf

• Section I (124.000) of your Provider Manual
  • https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/SectionI/Section_I.doc

• Eligibility verification job aid
  • MMIS_JobAid_Eligibility.pdf
Benefits (Section II of Provider Manual)

Arkansas Medicaid administers more than 50 programs. Here are just a few of the many benefits available to eligible beneficiaries (see Section II of the Physician Manual):

- Physician services
- Inpatient hospital
- Outpatient hospital
- Lab/X-ray
- Prescription
- Therapy (OT/PT/speech)

- Mental health
- Emergency room
- Long-term care
- Hospice
- Medical equipment
Timely Filing
What is a Timely Claim?

Section 302.000 of the AR Medicaid Manual Defines Timely Claims
The Code of Federal Regulations states “The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.” The 12-month (365 days) filing deadline applies to all claims, including:

- Claims for services provided to beneficiaries with joint Medicare/Medicaid eligibility
- Adjustment requests and resubmissions of claims previously considered
- Claims for services provided to individuals who acquire Medicaid eligibility retroactively

There are no exceptions to the 12-month filing deadline policy. The definitions and additional federal regulations in Section 3 will permit some flexibility for those who adhere closely to them.

Enhancement coming to change the 365 days limit to “no limit”. Providers will have a void/edit option.

All providers must submit claims within the 12-month (365 days) filing deadline to meet timely filing policy.
Medicare/Medicaid Crossover Claims

• The Medicare claim will establish timely filing for Medicaid, if the provider files with Medicare during the 12-month Medicaid filing deadline. Section 302.100 of the AR Medicaid Manual states that federal regulations permit Medicaid to pay its portion of the claim within six months after the Medicaid “agency or the provider receives notice of the disposition of the Medicare claim.”

• To submit a Medicare/Medicaid crossover claim that exceeds the timely filing conditions, enclose a signed cover memo or Medicaid Claim Inquiry Form requesting payment for the Medicaid portion of a Medicare claim filed to Medicare within 12 months of the date of service and adjudicated by Medicare more than 12 months after the date of service.

• Mail the cover letter, DMS-600, claim form and EOMB to:
  
  DXC Research  
  PO Box 8036  
  Little Rock, AR 72203
Claims with Retroactive Eligibility

• Retroactive eligibility does not constitute an exception to the filing deadline policy.
• If a claim is denied for beneficiary ineligibility, the provider may resubmit the claim when the patient becomes eligible.
• Occasionally, a Medicaid eligibility determination cannot be completed in time for service providers to file timely claims.
Claims with Retroactive Eligibility

• Arkansas Medicaid considers the pseudo beneficiary identification number 9999999999 to represent the beneficiary. Therefore, a claim containing that number is a clean claim if it contains all other information necessary for correct processing.

• Providers have 12 months from the approval date of the patient’s Medicaid eligibility to resubmit a clean claim after filing a pseudo claim.

• Providers may not electronically transmit any claims for dates of service over 12 months in the past to the Arkansas Medicaid fiscal agent.
Pseudo Claims

• To submit a claim for services provided to a patient who is not yet eligible for Medicaid, enter, on the claim form or on the electronic format (Portal or billing vendor/trading partner), a pseudo Medicaid beneficiary identification number, 9999999999. Medicaid will deny the claim. Retain the denial or rejection for proof of timely filing if eligibility determination occurs more than 12 months after the date of service.

• Providers have 12 months from the approval date of the patient’s Medicaid eligibility to re-submit a clean claim after filing a pseudo claim.

• When submitting the new claim after member has received eligibility, please ensure you submit this claim exactly as you submitted the pseudo claim. All provider numbers and procedure code/modifier information must match the original claim submitted.
Pseudo Claims

• Submit a paper claim to DXC Research, PO Box 8036, Little Rock, AR 72203
  o A copy of the Remittance Advice (RA) report page, documenting a denial of the claim dated within 12 months after the beginning date of service, or
  o A copy of the error response to an electronic transmission of the claim, computer-dated within 12 months after the beginning date of service, and
  o Any additional documentation necessary to explain why the error has prevented re-filing the claim until more than 12 months have passed after the beginning date of service
Adjustments

• If the fiscal agent has *incorrectly* paid a clean claim and the error has made it impossible to adjust the payment before 12 months have passed since the beginning date of service, a completed Adjustment Request Form (AR-004) must be submitted to the address specified on the form. Attach the documentation necessary to explain why the error has prevented re-filing the claim until more than 12 months have passed after the beginning date of service.

• Adjustment Request Form – Medicaid XIX AR 004 (*print Adjustment Request Form- Medicaid XIX AR-004*), available in Section V of the Arkansas Medicaid Manual

• Mail to:

  Adjustments  
  DXC Technology  
  P.O. Box 8036  
  Little Rock, Arkansas 72203
### Refund Checks

#### Service Details

<table>
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<tr>
<th>#</th>
<th>From Date</th>
<th>To Date</th>
<th>Place Of Service</th>
<th>EMG</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code Ptrs</th>
<th>Units</th>
<th>EPSDT</th>
<th>Family Plan</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
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<tbody>
<tr>
<td>1</td>
<td>01/01/2018</td>
<td>01/01/2018</td>
<td>11</td>
<td>N</td>
<td>99214</td>
<td>1</td>
<td>1.00 Unit</td>
<td></td>
<td></td>
<td></td>
<td>$100.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**No Adjudication Errors exist for this claim**

**No Other Insurance Details exist for this claim**

**No Attachments exist for this claim**
Arkansas Medicaid Manual

Please refer to Section 3 of the Arkansas Medicaid Manual for additional information related to timely claims

• Section 302.000 Timely Filing
• Section 302.100 Medicare/Medicaid Crossover Claims
• Section 302.400 Claims With Retroactive Eligibility
• Section 302.510 Adjustments

DXC Technology Provider Assistance Center (PAC)

PO Box 8036
Little Rock, AR 72203
1-800-457-4454
Summary

• Timely Claims
  • All providers must submit claims within the 12-month filing deadline from the date of service to meet timely filing policy
  • Providers may not *electronically* transmit any claims for dates of service *more than 12 months* in the past to the Arkansas Medicaid fiscal agent
Summary

• Providers have 12 months from the approval date of the patient’s Medicaid eligibility to re-submit a *clean* claim after filing a pseudo claim

• The *Medicare* claim will establish timely filing for Medicaid if the provider files with Medicare during the 12-month Medicaid filing deadline

• Providers have six months from date of Medicare paid date to submit their Medicare Crossover claim, if it was not submitted directly by Medicare Intermediary. From the *Medicare Crossover Provider Manual* “Federal regulations permit Medicaid to pay its portion of the claim within six (6) months after the Medicaid “agency or the provider receives notice of the disposition of the Medicare claim.”

• **Mailing address for claims past the timely filing deadline:**
  
  DXC Research  
  PO Box 8036  
  Little Rock, AR 72203
Ways to Submit Claims for Processing

• Arkansas Medicaid Provider Healthcare Portal

• Provider Electronic Solutions (PES): PES is decommissioning. Providers are strongly encouraged to transition to the Arkansas Medicaid Provider Portal.

• Vendor specs are available on the Medicaid website at
  https://medicaid.mmis.arkansas.gov/Provider/hipaa/compan.aspx

• Paper: Although paper submission is allowed, we highly recommend that you only submit a paper claim when you are asked to do so. Paper claims can take up to 30-45 days to process. *Using the paper claim submission could greatly postpone provider’s payment*
Healthcare Provider Portal
Healthcare Portal Features

- Online provider enrollment application
- Eligibility verification
- Submit all claim types (professional, institutional, dental, crossover and third-party)
- Ability to edit (adjust), void and copy claims
- View status of claims
- Attachments for claims and prior authorizations
- Prior authorization request and status check
- Real-time claims processing
- Remittance advise held up to seven years
- Secure correspondence
### Coverage Details for Beneficiary ID: 0001000001 - PATTI PPS/F from 1/1/2020 to 1/1/2020

#### Primary Care Provider
- **PCP Name:** PCP NOT REQUIRED
- **Effective Dates:** 01/01/2020-01/01/2020
- **Phone:**

#### Benefit Details

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Description</th>
<th>County</th>
<th>Effective Date</th>
<th>End Date</th>
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<td>654 PULASKI</td>
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#### Copayments

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<tr>
<td>10</td>
<td>Health Benefit Plan Coverage</td>
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<tr>
<td>33</td>
<td>(Chronic)</td>
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</tr>
<tr>
<td>35</td>
<td>(Dental Care)</td>
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</tr>
<tr>
<td>67</td>
<td>(Hospital)</td>
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</tr>
<tr>
<td>68</td>
<td>(Outpatient)</td>
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<td>66</td>
<td>(Emergency)</td>
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<tr>
<td>68</td>
<td>(Pharmacy)</td>
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<tr>
<td>68</td>
<td>(Professional (Physician) Visit - Office)</td>
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</tr>
<tr>
<td>66</td>
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<td>66</td>
<td>(Medical Health)</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>( Urgent Care)</td>
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</tbody>
</table>

#### Limit Details

- **Managed Care Assignment Details**
- **Tier Level Details**
- **Medforms/TPR**
- **EPSDT Well Child Service Details**
- **ARKIDS B Screening**
- **Adult Dental Service**
- **Demographic Details**
Claim Types Submitted on the Portal
Submitting a Crossover Claim on the Portal

Submit Professional Claim: Step 1

The * (in red) indicates required fields when the ADD button is selected.

Claim Type
- Professional
- Crossover Professional

Medicare Crossover Details

<table>
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<tr>
<th>Allowed Medicare Amount</th>
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<tr>
<td>Deductible Amount</td>
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<tr>
<td>Medicare Payment Amount</td>
<td></td>
</tr>
<tr>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

*Medicare Payment Date

Continue  Cancel
Submitting a Third-Party Liability (TPL) Claim on the Portal

Submit Professional Claim: Step 1

The * (in red) indicates required fields when the ADD button is selected.
TPL Documentation/Billing Guidelines

• If you are a provider of services to a Medicaid-eligible member, but the services you provide are not covered by the member’s primary insurance company, please see below for documentation and billing guidelines:
  o A provider can use either a certificate of benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment). They will need to keep this in the client file for auditing purposes.
  o It will be good for one year for either the Certificate of Benefits or Denial EOB.
  o Example: Get certificate or denial dated 01/01/2018. The provider could use it through 12/31/2018. They would say “yes” they billed the insurance using a denial date of in this example 01/01/2018 and $0.00 payment amount. Be sure to include Claim Filing Indicator.
AFMC Prior Authorization Process Types on the Portal

- Anesthesia
- Assistant surgeon
- Hyperalimentation
- Hyperbaric oxygen therapy
- Inpatient services
- Inpatient services extension
- Lab and radiology
- Lab – molecular pathology
- Orthotics and prosthetics
- Personal care – under age 21
- Personal care – under 21 Extension
- Physician-administered drugs
- Professional services
- Targeted case management
- Ventilators, equipment
- Viscosupplementation

Note: These process types are processed by AFMC
Medical/Dental Prior Authorization Process
Types on the Portal

- Augmentative communication device Evaluation
- DDS services
- Developmental rehab services
- Disposable medical supplies
- First Connections
- Hearing services
- Home health visit extensions
- Independent Choices
- Other medical service
- Other prosthetics
- Private duty nursing

- Specialized service
- Title V
- Vision
- Adult dental
- Child dental
- Orthodontics

Note: These process types are processed by the State
Healthcare Portal Enhancements Coming Soon!

- Save button for claim entry for all claim types
- Provider affiliation display panel
- Treatment history panel
- Provider enrollment
- PA extension button
- ARKids B co-pay information
- File size increased for attachments
- Files exchange – documentation list
Mail Paper Claims to:

**DXC Technology**
Attn: Claims
P.O. Box 8034
Little Rock, AR 72203

**Special Claims**
Attn: Research Analysts
P.O. Box 8036
Little Rock, AR 72203

**Crossover Claims**
DXC Technology
P.O. Box 34440
Little Rock, AR 72203

*Please do not send claims to AFMC.*
Training Tools and Resources

- Medicaid website: https://medicaid.mmis.arkansas.gov
- Provider manuals (see slides)
- FAQs
- Vendor specs
- Fee schedule
What’s New for Arkansas Medicaid Providers

Content updated March 5, 2019

View system status.

Jump to

- Provider-led Arkansas Shared Savings Entity (PASSE) UPDATE
- IMPORTANT UPDATE: Entry of Electronic PAs Using AFMC ReviewPoint Portal to Continue
- Provider-led Arkansas Shared Savings Entity (PASSE) Will Go Live on March 1, 2019
- PI/MU Deadline for 2018 Attestations
- Electronic Funds Transfer Required for All Providers Billing All Claims
- New Provider Manual Updates
- New RA Messages

Provider-led Arkansas Shared Savings Entity (PASSE) UPDATE

Added 3/4/19
Provider Manuals

• Section I
  o General policy
  o General information, sources, beneficiary eligibility and responsibilities, provider participation, administrative (and noncompliance) remedies and sanctions, PCP case management program, and required services and activities

• Section II
  o Provider manual (varies by provider type)
  o Program or provider specific information, program coverage, prior authorization, reimbursement and billing procedures
Provider Manuals

• Section III
  Billing information: general information, remittance advice and status report, adjustment request, additional or other payment sources, pseudo claims and reference books

• Section IV
  Glossary: Arkansas Medicaid acronyms and terms

• Section V
  Claim forms, Arkansas Medicaid forms, contacts and links
Provider Manuals

• Appendix A
• Update log: Update number and effective date (formerly Appendix A)
• Number and release dates for updates
• Program publications/notifications: transmittal letters, official notices, remittance advice messages and notices of rule making
Things to Remember

• Claims submitted electronically must be entered by 6 p.m. on Friday
• Medicaid 101 webinar conducted the last Tuesday of each month (unless otherwise noted)
• Always check manuals, official notices, remittance advice banners and fee schedules for up-to-date information
Evaluations

Your feedback is important to us!
Please take time to complete the evaluation that will be emailed to you. Attendance certificate will be available to print.

Thank you for attending today!
Questions?