ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

PROVIDER DETERMINATION

By submitting this form, your agency is indicating that the identified participant is ill-suited for the SNAP CAN component your agency has enrolled them in and that there are no other components available within your agency that the participant is likely better suited for. The Provider Determination (PD) form is required to be sent via email, within 10 days of the decision, to easnaetreports@azdes.gov and faaramgt@azdes.gov. The Subject Line must state Provider Determination.

As needed, please attach any documentation (e.g. incident reports, case notes, etc.) supporting your decision. PD instructions can be found in the Supplemental Nutrition Assistance Program Career Advancement Network (SNAP CAN) Policy Manual.

The participant will receive notification within 10 days of the receipt of this form, providing information on the PD process, their rights and how to contact the state agency if they would like to request a reassessment of their referral prior to their next renewal.

PARTICIPANT'S INFORMATION

Participant's Name: ____________________ Phone No.: ____________

Participant's Case Number or SSN: ____________ Participant's Date of Birth: ____________

PROVIDER'S DECISION

Description and information for decision:

Recommend next steps based on assessment:

PROVIDER INFORMATION

Provider Agency: ____________ Phone No.: ____________ Email: ____________

Staff Member (Name or Identifier): ____________________ PD Decision Date: ____________

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