ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Office of Licensing Certification and Regulation (OLCR)
Home and Community Based Services (HCBS)

APPLICATION FOR INITIAL HCBS CERTIFICATION
for Independent Providers

Complete all questions accurately and legibly. Falsification and/or omission of information may result in delay or denial (A.A.C. R6-6-1514) of HCBS certification.

A.R.S. 41-1030. **Invalidity of rules not made according to this chapter; prohibited agency action; prohibited acts by state employees; enforcement; notice.**

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.

E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the agency's adopted personnel policy.

SECTION 1: APPLICANT INFORMATION

Applicant's Name *(Last, First, M.I.)* _____ Application Date _____

List all Prior Names Used _____

SOC. SEC. NO. _____ Date of Birth _____

Mailing Address *(No.,Street, Apt., City, State, ZIP Code)* _____

Physical Address *(If different from above)* _____

Phone Number *(Home)* _____ Phone Number *(Mobile)* _____

Email _____

1. Have you ever been licensed/certified to care for children/adults? If yes, provide dates, state, and type (e.g., day care,ACYF,) of license/certification and attach copy if available. From: _____ To: _____ State: _____ Type: _____ From: _____ To: _____ State: _____ Type: _____	☐ Yes ☐ No
2. Have you ever had a license/certificate denied, revoked or suspended? *(If yes, attach an explanation.)*	☐ Yes ☐ No
3. Have you ever been subject of inquiry by the Department of Child Safety (DCS) or Adult Protective Services (APS)? *(If yes, attach an explanation.)*	☐ Yes ☐ No
4. If services are to be delivered in facility/residence of the applicant, has any adult household member been subject of inquiry by DCS and/or APS? *(If yes, attach an explanation.)*	☐ Yes ☐ No ☐ N/A
5. Have you ever been registered to provide services for AHCCCS? If yes, what is/was your AHCCCS number? _____	☐ Yes ☐ No
6. Does the person with developmental disabilities you intend to serve reside with you?	☐ Yes ☐ No
7. Select ALL categories of service you are requesting: ☐ 23 Homemaker ☐ 28 Attendant Care ☐ 26 Respite ☐ 32 Habilitation ☐ 31 Non-Emergency Transportation	
8. Do you plan to transport members while providing services? If you answered Yes, ensure driver license, auto insurance and auto registration are listed in Section 4	☐ Yes ☐ No

See page 3 for EOE/ADA disclosures

9. Do you plan to deliver services at your home for members who do not reside with you? If you answered Yes, ensure adult household member information is entered in Section 4. Do any other adults (non-DDD) reside in your home? If Yes, ensure adult household member(s) listed in Certification Requirements section.	☐ Yes ☐ No ☐ Yes ☐ No

SECTION 2: WORK HISTORY
(NOT REQUIRED FOR PARENT OR IMMEDIATE FAMILY MEMBER)
LIST MOST RECENT JOB FIRST OR ATTACH RESUME.

Employer's Name _____

May We Contact Your Supervisor ☐ Yes ☐ No Phone No. _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Supervisor's Name *(Last, First)* _____

Length of Employment *(From/To)* From: _____ To: _____

Job Title/Occupation _____

Job Duties _____

Employer's Name _____

May We Contact Your Supervisor ☐ Yes ☐ No Phone No. _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Supervisor's Name *(Last, First)* _____

Length of Employment *(From/To)* From: _____ To: _____

Job Title/Occupation _____

Job Duties _____

SECTION 3: BACKGROUND

Highest Grade Completed _____ Degree _____

Describe any special skills, professional licenses, training and/or previous experience with children/adults related to the service you want to provide *(i.e., babysitting, volunteer, companion, organized sports/recreation, day care, camps, nursing homes, hospitals, and working with disabled individuals and indicate length of experience in years)*

SECTION 4: CERTIFICATION REQUIREMENTS

Complete the following:

CERTIFICATION REQUIREMENTS	DATE *(MM/DD/YY)*	N/A	VERIFIED BY PROVIDER COORDINATOR *(FOR DDD USE ONLY)*
a. CPR Expiration			☐
b. First Aid Expiration			☐
c. Article 9 Expiration			☐
d. Fingerprint Clearance Card Expiration		☐	☐

CERTIFICATION REQUIREMENTS *(CONTINUED)*	DATE *(MM/DD/YY)*	N/A	VERIFIED BY PROVIDER COORDINATOR *(FOR DDD USE ONLY)*
If you selected N/A, Name of Member: Relationship to Member:			
e. Criminal History Self-Disclosure			☐
f. Driver License Expiration		☐	☐
g. Auto Insurance Expiration		☐	☐
h. Auto Registration Expiration		☐	☐
i. Household Member Fingerprint Card Expiration		☐	☐
Name:			
j. Household Member Fingerprint Card Expiration		☐	☐
Name:			
k. Household Member Fingerprint Card Expiration		☐	☐
Name:			
l. Household Member Criminal History Self Disclosure		☐	☐
Name:			
m. Household Member Criminal History Self Disclosure		☐	☐
Name:			
n. Household Member Criminal History Self Disclosure		☐	☐
Name:			

I swear under penalties of law including perjury, false swearing, or unsworn falsification, that the information I have provided on this form is true and accurate to the best of my knowledge.

Provider Signature _____ Date _____

SECTION 5: FOR DDD USE ONLY

Print DDD Provider Coordinator's Name _____

Date Application Received by District _____ Phone Number _____

By signing, I affirm that I have reviewed this application for completeness and reviewed the provider's certification file.

Provider Coordinator's Signature _____ Date _____