DDD-1790A FORFF (4-17)

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

WITHDRAW HCBS CERTIFICATION

DATE REC'D BY DES/DDD OLCR:

LOGIN DATE:

LOGIN BY:

INSTRUCTIONS: Please complete the required information. Check the appropriate box below and indicate the reason for your decision to withdraw/discontinue HCBS certification in the spaces provided.

APPLICANT INFORMATION

FEIN/SSN *(Tax ID Number)* _____ AHCCCS ID Number _____

Applicant's Name *(Last, First, M.I.)* / *OR* Agency Name _____

Agency Primary Contact Person's Name *(First, Last)* – If applicable _____

Mailing Address *(No., Street, P.O. Box)* _____

City _____ State _____ ZIP Code _____

Day/Business Phone Number _____ Evening/Emergency Phone Number _____

PLEASE CHECK ONE

- ○ I wish to voluntarily withdraw my initial application for HCBS certification.
- ○ I wish to terminate my certification to provide home and community based services.
- ○ I wish to notify the DES/DDD of my intent not to renew my HCBS certification.

I WISH TO END HCBS CERTIFICATION FOR THE FOLLOWING REASON *(Please check one)*

- ◉ Moved out of state (T33/MOVE)
- ○ No longer interested in providing services (T34/VOL)
- ○ Agency ownership change (T51/OWNER)
- ○ Retired (T55/RETIR)
- ○ Out of business/closed (T56/OOB)
- ○ Other (T30/OTH) *(Specify reason)* _____

_____ _____

Applicant/Agency Representative Signature — Requested Date of Withdrawal

Please return this form to: *(To be completed by DES DDD OLCR)*

HCBS District Representative's Name *(Print Name)* _____

Phone Number _____ Address *(No., Street, P.O. Box)* _____

City _____ State _____ ZIP Code _____

FOR DES DDD OLCR STAFF USE ONLY

- ☐ Failure to recertify (T28/FAIL)
- ☐ Death (T32/DEATH)
- ☐ Moved out of state (T33/MOVE)
- ☐ Multiple AHCCCS ID (T35/MULTI)
- ☐ Provider type change (T52/PRCHG)
- ☐ Returned Mail (T54/MAIL)
- ☐ DES termination (T58/DES)
- ☐ Rescind withdrawal submitted on: _____
- ☐ End date of previous certificate: _____
- ☐ Effective date of new certificate: _____
- ☐ Other (T30/OTH) _____

_____ _____

DES DDD OLCR Signature — Effective Date of Withdrawal

_____ _____

DES DDD District Representative's Name *(Print Name)* — Date Processed

Address *(No., Street, P.O. Box)* _____

City _____ State _____ ZIP Code _____

Phone Number _____ Mail Drop Code _____

See reverse for EOE/ADA/LEP/GINA disclosures

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Ayuda gratuita con traducciones relacionadas con los servicios del DES esta disponible a solicitud del cliente.