ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

APPLICATION FOR RENEWAL OR AMENDED HCBS CERTIFICATE
For Independent Providers

Action Requested: *(Check all that apply)* ☐ Renewal ☐ Amendment ☐ Reactivation

Amendment Type: *(Check all that apply)*
☐ Name Change ☐ Address Change ☐ Delete Service ☐ Add Service
☐ Change of phone number or email ☐ Change of service location
☐ Add Household Member ☐ Remove Household Member

Section 1: Applicant Information

Application Date: _____ QCID: _____ AHCCCS ID: _____

Name *(Last, First, M.I.)*: _____ Date of Birth: _____

Mailing Address *(No., Street, Suite or Apt. No.)*: _____

Physical Address *(if different from above)*: _____

City: _____ State: _____ ZIP Code: _____

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

Email: _____

Section 2: Certification Details

1) Select ALL categories of service you are requesting:
☐ Homemaker ☐ Attendant Care ☐ Respite ☐ Habilitation, Support
☐ Habilitation, Individually Designed Living Arrangement

2) Do you transport members while providing services? ☐ Yes ☐ No

3) Do you deliver services at your home for members who do not reside with you? ☐ Yes ☐ No
If you answered Yes, complete the following:
a. What is the date of your last home inspection? _____
b. Do any other adults (non-DDD) reside in your home? ☐ Yes ☐ No

4) Provide the following certification information:	**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		☐	☐
If you selected N/A, Name of Member: Relationship to Member:		DOB of 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:			

See page 2 for EOE/ADA disclosures

4) Provide the following certification information *(continued)*:	**Date** *(mm/dd/yy)*	**N/A**	**Verified by Provider Coordinator** *(For DDD use only)*
l. Household Member Criminal History Self Disclosure		☐	☐
Name:			
m. Household Member Criminal History Self Disclosure		☐	☐
Name:			
n. Household Member Criminal History Self Disclosure		☐	☐
Name:			

Notes:

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: _____

For DDD Use Only

Print DDD Provider Coordinator's Name: _____

Date Application Received by District: _____ Phone Number: _____

Notes:

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

Provider Coordinator's Signature: _____ Date: _____