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:
23 Homemaker 28 Attendant Care 26 Respite 32 Habilitation 31 Non-Emergency Transportation

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:			
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: ______________

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local