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

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.

Applicant's Name *(Last, First, M.I.)* Agency's Name *(if applicable)* _____

List all Prior Names Used _____

SOC. SEC. No./FEIN/Tax ID No. _____ Business/Home Phone No. _____

Applicant's Signature _____ Date _____

1. Have you ever been licensed/certified to care for children/adults? If yes, dates, state, and type (e.g., day care,ACYF,) of license/certification and attach copy if available. 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 Division 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. Have you ever worked for or are you currently working for an AHCCCS-certified agency? If yes, name of agency/facility _____ From: _____ To: _____	☐ Yes ☐ No
7. Are you currently Medicare-certified?*(For Home Health Agencies Only)* Attach copy if available.	☐ Yes ☐ No ☐ N/A
8. Does person with developmental disabilities live in the same residence as the applicant?	☐ Yes ☐ No

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 _____

See page 2 for EOE/ADA/LEP/GINA disclosures

WORK HISTORY *(NOT REQUIRED FOR PARENT OR IMMEDIATE FAMILY MEMBER)* List most recent job first or attach resume. (CONTINUED)

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 _____

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)*

Routing: **ORIGINAL** – LCR (2HF1); **COPY** – HCBS/District Office; **COPY** – HCBS Applicant