

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? <i>(If yes, attach an explanation.)</i>	Yes	No	
3. Have you ever been subject of inquiry by Division of Child Safety (DCS) or Adult Protective Services (APS)? <i>(If yes, attach an explanation.)</i>	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? <i>(If yes, attach an explanation.)</i>	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? <i>(For Home Health Agencies Only)</i> 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 _____

**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

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. Disponible en español en línea o en la oficina local.