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

AGENCY COMPLIANCE AUDIT CHECKLIST

Agency Name: _____

Agency Representative's Name: _____ Audit Date/Time: _____

☐ 03 Respiratory Therapy ☐ 05 Occupational Therapy ☐ 06 Physical Therapy ☐ 07 SPT/Hearing Therapy
☐ 19 ICF/MR ☐ 20 Hospice ☐ 23 Homemaker ☐ 26 Respite
☐ 28 Attendant Care ☐ 29 Home Health Aide ☐ 30 Home Health Nurse
☐ 31 Non-Emergency Transportation ☐ 32 Habilitation ☐ 39 Personal Care Attendant
☐ 42 DD Day Care ☐ 46 Environmental Modifications ☐ Other: _____

Total Number of Direct Care Staff: _____ Total Files Audited: _____

Are services delivered at this location? ☐ Yes ☐ No If Yes, note the address, date and source of the inspection.

Address *(No., Street, City, State, ZIP)*: _____

Date: _____ Inspected By: _____

Has an OLCR inspection been completed and passed for each site used to provide services? ☐ Yes ☐ No
A list of sites and current inspection dates must be included with the Agency Staff Matrix. -OR- ☐ N/A Services are provided only in the consumer's home.

Is Agency Medicare certified? If Yes, attach copy of DHS license. ☐ Yes ☐ No

Transporting? ☐ Yes ☐ No If Yes, is insurance/registration current? ☐ Yes ☐ No
If Yes, are copies of vehicle insurance and registration included with the Agency Staff Matrix? ☐ Yes ☐ No

Are classes for CPR, first aid, Article 9 or CIT given by Agency? If Yes, attach copies of the instructor's credentials.
☐ Yes ☐ No

Does the Director/Owner also provide direct care services to clients? ☐ Yes ☐ No
If Yes, the Director/Owner is listed on the Agency Staff Matrix. ☐ Yes ☐ No
If No, verify the Director/Owner has a current valid fingerprint clearance card. F.C.C. exp. date: _____

Received current Agency Staff Matrix at the time of the audit? ☐ Yes ☐ No

Is the Agency requesting Central Registry checks for all direct care staff? ☐ Yes ☐ No

Notes/Findings: *(Use page 2 for additional space)*

☐ Agency was in full compliance with certification standards with the files and records reviewed during the audit.
☐ Agency was not in full compliance but all violations have been corrected.
☐ Agency was not in full compliance. Evidence of corrections(s) for violation(s) cited and a written description of action taken to ensure ongoing compliance must be submitted to OLCR by the agency within 30 days.

By signing, I, the Service Provider Representative, affirm that the audit reflects the documentation made available to the HCBS Auditor.

Service Provider's Name *(Print or type)*: _____

Service Provider's Signature: _____ Date: _____

HCBS Auditor's Name: _____

HCBS Auditor's Signature: _____ Date: _____

Routing: **Original** – Central Office; **Canary** – Service Provider

See page 2 for EOE/ADA disclosures

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Notes/Findings: