LCR-1028A FORFF (7-23)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Office of Licensing, Certification & Regulation (OLCR) • Home and Community Based Services (HCBS)

AGENCY ROSTER OF EMPLOYEES

Agency Name: ______________________________ Total No. of Employees: __________

FEIN *(Tax ID No.)*: ______________ AHCCCS Provider's ID or Group Pay ID: ______________

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

Site Address Where the Following Employee's Records are Kept *(Use a different sheet for each site)*: ______________

03 ☐ Respiratory Therapy
05 ☐ Occupational Therapy
06 ☐ Physical Therapy
07 ☐ Speech/Hearing Therapy
20 ☐ Hospice
23 ☐ Housekeeping
26 ☐ Respite
28 ☐ Attendant Care
☐ Parent
☐ Immediate Relative
☐ Companion
29 ☐ Home Health Care
30 ☐ Home Health Nursing
31 ☐ Transportation
32 ☐ Habilitation
☐ Hourly
☐ Daily
42 ☐ Day Treatment and Training
☐ Other

Note: Any blanks must be explained. Enter all dates MM/DD/YYYY

NAME *(Last, First)*		First Aid Exp Date	Vehicle Insurance Exp Date ① ☐ N/A	CIT Exp Date ☐ N/A	CHS Disclosure	3 Reference letters on file ☐ Yes ☐ No	Services Delivered at: ☐ Client Residence ☐ Provider Res/Fac ③ ☐ Both ③ Enter AHCCCS # if applicable
SSN *(Last Four)*	TITLE	Application/Resume ☐ Yes ☐ No	Drivers License Exp Date ① ☐ N/A	Orientation to Client ☐ Yes ☐ No	FP Exp Date	Service Provided	
DATE HIRED	PROOF OF AGE/DOB	Article 9 Exp Date	Vehicle Registration Exp Date ① ☐ N/A	CPR Exp Date	FP Card/Application #	Prof License Exp Date ②	
NAME *(Last, First)*		First Aid Exp Date	Vehicle Insurance Exp Date ① ☐ N/A	CIT Exp Date ☐ N/A	CHS Disclosure	3 Reference letters on file ☐ Yes ☐ No	Services Delivered at: ☐ Client Residence ☐ Provider Res/Fac ③ ☐ Both ③ Enter AHCCCS # if applicable
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DATE HIRED	PROOF OF AGE/DOB	Article 9 Exp Date	Vehicle Registration Exp Date ① ☐ N/A	CPR Exp Date	FP Card/Application #	Prof License Exp Date ②	

① Current valid driver's license MUST be on file for each employee providing transportation as well as proof of valid vehicle registration and liability insurance for each vehicle use to transport DDD individuals, or check NA if not transporting. ② Please attach a copy of the professional license *(Nurse, Therapist, Day Care, ACYF Home, DDD Developmental Home)*. ③ If Provider or Both, Fire and Health Inspections are required.

I swear, under penalties of law including perjury, false swearing or unsworn falsification, that the information I have provided on this form is true, accurate and complete to the best of my knowledge.

Provider's Signature: ______________________________ Date: __________

INSPECTIONS

Agency Site's Name: _____

Agency Site's Address *(No., Street, City, State, ZIP)*: _____

Initial Date of Health/Safety Inspection: _____ Last Date of Fire Inspection: _____

Agency Site's Name: _____

Agency Site's Address *(No., Street, City, State, ZIP)*: _____

Initial Date of Health/Safety Inspection: _____ Last Date of Fire Inspection: _____

Agency Site's Name: _____

Agency Site's Address *(No., Street, City, State, ZIP)*: _____

Initial Date of Health/Safety Inspection: _____ Last Date of Fire Inspection: _____

Agency Site's Name: _____

Agency Site's Address *(No., Street, City, State, ZIP)*: _____

Initial Date of Health/Safety Inspection: _____ Last Date of Fire Inspection: _____

LIST ALL VEHICLES USED TO TRANSPORT

MAKE	YEAR	LICENSE	REGISTRATION EXPIRATION DATE	LIABILITY INSURANCE EXPIRATION DATE