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



DATE RECEIVED BY DES/DDD OLCR:

# REQUEST TO WITHDRAW HCBS CERTIFICATION

**INSTRUCTIONS:** Please complete the required information. Check the appropriate box below and indicate the reason for your decision to withdraw/discontinue HCBS certification in the spaces provided.

## APPLICANT INFORMATION:

Type of provider certification to be withdrawn:

- ◯ Independent Provider
- ◯ Qualified Vendor
- ◯ DDD Group Home
- ◯ Other: _____

FEIN/SSN *(Tax ID Number)*: _____ AHCCCS ID Number: _____

Applicant's Name *(Last, First, M.I.)* / *OR* Agency Name: _____

Agency Primary Contact Person's Name *(First, Last)* – If applicable: _____

Mailing Address *(No., Street, P.O. Box)*: _____

City: _____ State: _____ ZIP Code: _____

Day/Business Phone Number: _____ Email: _____

## PLEASE CHECK ONE:

- ◯ I wish to voluntarily withdraw my application for HCBS certification.
- ◯ I wish to terminate my certification to provide home and community based services.
- ◯ I wish to terminate a DDD group home certification.
  - Group Home Name: _____
  - Group Home Address: _____
  - Group Home AHCCCS ID: _____
- ◯ I wish to notify the DES/DDD of my intent not to renew my HCBS certification.

## I WISH TO END HCBS CERTIFICATION FOR THE FOLLOWING REASON:

◯ Moved out of state ◯ No longer interested in providing services ◯ Agency ownership change

◯ Retired ◯ Out of business/closed ◯ Other *(Specify reason)*: _____

Applicant/Agency Representative Signature: _____ Date: _____

Requested Date of Withdrawal: _____

## INDEPENDENT PROVIDERS ONLY, RETURN THIS FORM TO YOUR PROVIDER COORDINATOR.

***For Independent Provider Coordinator Use Only***

HCBS Provider Coordinator's Name *(Print Name)*: _____

Phone Number: _____ Email: _____

Provider Coordinator's Signature: _____ Date: _____

See page 2 for EOE/ADA disclosures

## FOR DES DDD OLCR STAFF USE ONLY

Check the appropriate box to indicate the reason for the withdrawal:

- ◯ Failure to Recertify/Expiration
- ◯ Death
- ◯ Moved out of state
- ◯ Returned Mail
- ◯ DES termination/Adverse action
- ◯ Agency ownership change
- ◯ Group home closure
- ◯ Voluntary Withdrawal
- ◯ Other: _____

DDD HCBS Specialist Name *(Print name)*

Effective Date of Withdrawal

DDD HCBS Specialist Signature

Date Processed