

## RECREREDENTIALING CHECKLIST

Please read this checklist thoroughly and complete it in its entirety. The checklist may not be exhaustive of all necessary materials and information needed for your recredentialing application. It is meant to serve as a guide for vendors to submit the documents required to complete the recredentialing process. Thank you!

**Complete and return this form and provide all required COPIES by replying via email to [DDCCredentialing@azdes.gov](mailto:DDCCredentialing@azdes.gov):**

### REQUIRED FOR ALL PROVIDERS

- Government Issued Photo ID** copies for EACH Owner and Signatory listed on CAS/Focus portal
  - Signatory Names: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- Last 4 Digits of Social Security Number** for EACH Owner and Signatory listed on CAS/Focus portal
  - Signatory 1:     Signatory 2:     Signatory 3:
- Criminal History Self Disclosure Affidavit(s)** (Must be **notarized**) for EACH Owner and Signatory listed on CAS/Focus
- IRS Letter** assigning Employer Identification Number (EIN)
- W-9 Form [SIGNED]**
- Qualified Vendor Assurances and Submittals [SIGNED]** Retrieved from CAS/Focus (all 5 pages)
- Active Arizona Corporation Commission (ACC) Business License** (Copy of ACC website entity search accepted)
- Active Certificate(s) Of Insurance (COI)** demonstrating the following required coverage:
  - Commercial General Liability coverage
  - Business Automobile Liability coverage
  - Worker's Compensation and Employers' Liability coverage
    - OR \*Sole Provider Waiver form** (\*Only applies if not carrying Workers Compensation)
  - Professional Liability coverage
  - Sexual Abuse and Molestation (SAM) coverage
- Active (HCBS) Home and Community Based Services / OLCR Certificate OR STATUS Update** from CAS/Focus
- Active Fire Inspection Report(s) ONLY** required for vendors adding Day Program Services **AND/OR** Group Homes
- AHCCCS ID Provider # Notification Letter**
  - Please list the Provider AHCCCS ID # : \_\_\_\_\_
- Organizational NPI number** (If any): \_\_\_\_\_
- RECREREDENTIALING CHECKLIST (This entire form) [SIGNED]**

### SECTION A: GROUP HOME & SUPPORTIVE/ASSISTED LIVING PROVIDERS ONLY

If you are a vendor with group homes, you **must** provide the information and additional copies of the following:

- # of Total **ACTIVE/OPEN** Group Homes: \_\_\_\_\_
  - REQUIRED** Group Home Information Sheet provided by the Credentialing Department
  - REQUIRED** (HCBS) Home and Community Based Services / OLCR **CERTIFICATES** for each group home
  - REQUIRED** (AZDHS) Arizona Department of Health Services License **CERTIFICATES** for each group home
  - REQUIRED** Fire Inspection Reports for each group home
  - Expansion Letter(s)** for group homes (If any)

(\*Please note that if a group home is missing any of the required documents above, your application may be on **hold**.)

**SECTION B: INDIVIDUAL PROVIDERS or THERAPY SERVICE PROVIDERS ONLY**

→ To qualify for each of these services, you must demonstrate **proof** of a hired therapist.

*Please fill out the information and provide additional copies of the following:*

**For OCT - Occupational Therapy Services:**

- Full Name of **Occupational Therapist:** \_\_\_\_\_
- AHCCCS ID # of Therapist: \_\_\_\_\_
- NPI # of Therapist: \_\_\_\_\_
- Copy of *Arizona Board of Occupational Therapy Examiners License*
- Copy of *National Board for Certification in Occupational Therapy, Inc. Certificate*

**For PHT - Physical Therapy Services:**

- Full Name of **Physical Therapist:** \_\_\_\_\_
- AHCCCS ID # of Therapist: \_\_\_\_\_
- NPI # of Therapist: \_\_\_\_\_
- Copy of *Arizona State Board of Physical Therapy License*
- Copy of *American Board of Physical Therapy Certificate*

**For SPT - Speech Therapy Services:**

- Full Name of **Speech Therapist:** \_\_\_\_\_
- AHCCCS ID # of Therapist: \_\_\_\_\_
- NPI # of Therapist: \_\_\_\_\_
- REQUIRED** Copy of *American Speech-Language-Hearing Association (ASHA) Certification*
- Copy of *AZDHS Speech Language and Hearing Provider License*

**For HAM - Music Therapy Services (Individual Providers):**

- Full Name of **Music Therapist:** \_\_\_\_\_
- AHCCCS ID # of Therapist: \_\_\_\_\_
- NPI # of Therapist: \_\_\_\_\_
- REQUIRED** Copy of *Certification of Board of Musical Therapy*

\_\_\_\_\_  
Name of Agency/Organization

\_\_\_\_\_  
Name of Authorized Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Credentialing Unit**  
**Division of Developmental Disabilities**  
 4000 N Central Ave, Ste #200  
 Phoenix AZ, 85012  
 Mail Drop: 2HA3  
 Office: (602) 771-0320  
 Toll-free: (877) 867-6443

***Thank you for completing your application.***

## DEMOGRAPHIC UPDATES

Please fill out this form to indicate any demographic changes that were made:

### OWNER/SIGNATORY UPDATES

Did any vendor owner/signatories change?  Yes  No

If "Yes", please list the former owners/signatories and the new owners/signatories:

**Former Owners/Signatories:**

**New Owners/Signatories**

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

### CONTACT INFORMATION UPDATES

Did any vendor contact information change?  Yes  No

If "Yes", please list the former contact information and the updated contact information.

**Previous Email & Phone Number**

**New Email & Phone Number**

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

### SITE ADDRESS UPDATES

Did any site addresses change?  Yes  No

If "Yes", please list the name of the site, the old address, and the new address:

Name of Site	Old Site Address	New Site Address

Have **ALL** of these changes been updated on **CAS/Focus**?  Yes  No  No changes made

Have **ALL** of these changes been updated on the **AHCCCS Provider** site?  Yes  No  No changes made

**If "No" was answered, please update these demographic changes at your earliest convenience to prevent delays in your recertification process. Thank you!**