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

CERTIFICATION ID NUMBER

APPLICATION FOR INITIAL HCBS CERTIFICATION
For Qualified Vendors and Agencies

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.

Action Requested: Initial Reactivation

Application Date: ____________________ AHCCCS ID *(if known)*: ____________________

Agency/Business Name: ____________________ FEIN/Tax ID No.: ____________________

Mailing Address *(No., Street, Suite or Apt. No.)*: ____________________

City: ____________________ State: ____________________ ZIP Code: ____________________

Agency/Business Phone: ____________________ Emergency/After Hours Phone: ____________________

E-mail: ____________________ Fax: ____________________

Physical/Service Address *(if different from above)*: ____________________

City: ____________________ State: ____________________ ZIP Code: ____________________

Name of CEO/Owner: ____________________

Name of Authorized Person Completing Application: ____________________

Categories of Service *(Please check all services that you are applying for)*:

01 Medicine
03 Respiratory Therapy
05 Occupational Therapy
06 Physical Therapy
07 Speech/Hearing Therapy
19 ICF/MR
20 Hospice Inpatient Care
23 Homemaker Services
26 Respite Care Services
28 Attendant Care
29 Home-Health Aid Service
30 Home-Health Nurse Service
31 Non-Emergency Transportation
32 Habilitation Hourly Daily Both
39 Personal Care Services
42 DD Programs (DD Day Care Programs)
45 Rehabilitation
46 Environmental
47 Mental Health Services

1. Has this agency or the CEO/Owner ever been registered with AHCCCS to provide services? Yes No

   If so, what was the AHCCCS ID? ____________________

2. Has the agency or CEO/Owner ever been licensed or certified to provide care to children or adults? Yes No
   If yes, please explain:

3. Has the agency or the CEO/Owner ever had a license/certificate denied, revoked or suspended? Yes No
   If yes, please submit a detailed written explanation.

4. Has the agency CEO/Owner ever been the subject of a substantiated report of abuse, neglect or exploitation of a child or vulnerable adult? Yes No
   If yes, please submit a detailed written explanation.

5. Is the agency currently Medicare Certified? *(Home Health Agencies only)* Yes No
   If yes, attach a copy of the certification.

See page 2 for EOE/ADA disclosures

6. Do you already have a contract to provide services to members of the Division? Yes No
   If yes, list contracting entities (DDD, MCO, etc.):

7. Please provide a statement attesting to the qualifications and fitness of your agency to provide services
   a. You may attach a resume of the CEO/Owner or resumes from key staff
   b. Describe any special skills, professional licenses, training and/or previous experience with children/adults related to the service you want to provide

8. I understand that all direct care providers and key staff must meet the HCBS requirements contained in the Arizona Administrative Code (A.A.C.) R6-6-1501 et seq. Yes No
9. I understand that HCBS certification must be renewed annually. Failure to maintain HCBS certification may impact my ability to bill for services. Yes No
10. I understand that all service sites must be inspected by the Division prior to use and every two years thereafter. It is my responsibility to track inspection timeframes and request an inspection when needed. Yes No
11. I understand it is my responsibility to notify the division of any changes to the HCBS certificate such as, change of address, change of ownership, change of FEIN, addition of services, deletion of services, name change, change of contact information. Yes No

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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.

Signature: ______________________________ Date: ______________

FOR OLCR USE ONLY

Certification Date: ______________ Expiration Date: ______________ Effective Date of Action: ______________

AHCCCS ID *(if known)*: ______________________ AHCCCS Provider Type *(if known)*: ______________________

Comments: ____

Processed By: ______________________________ Process Date: ______________

Reviewers Signature *(By signing, I affirm that all data has been verified and documentation is on file)*

Signature: ______________________________ Date: ______________

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • 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