ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

Community Service Agency Title XIX Certification
INITIAL APPLICATION

Provider Information

Applicants must submit an application for each provider facility

Date of Application: ________/_________/________

AHCCCS Provider ID #:______________________________
National Provider Identification (NPI): ___________________

Provider Name:

Provider Phone Number: (   ) ________ - ______________

Provider E-Mail Address: _______________________________

Provider Administrative Address (if applicable):
Street ____

City: ______________________________________ State: ______
Zip: ________________ County: __________________________

Provider Facility Address[1]:
Street ____

City: ______________________________________ State: ______
Zip: ________________ County: __________________________

Provider Mailing Address:
Street ____

City: ______________________________________ State: ______
Zip: ________________ County: __________________________

Program Director:

Name:____

Credentials:____

Phone Number:______________________________________

Tax ID#:____

OR

Social Security Number:_________________________________

Please mark a "C" for each T/RBHA the applicant has a contract with and an "I" for each T/RBHA the applicant intends to contract with.

__ CPSA-3 __ Cenpatico-4

__ CPSA-5 __ NARBHA

__ Cenpatico-2 __ Magellan

__ Navajo Nation __ Gila River Tribal RBHA

__ Pascua Yaqui Tribal RBHA __ White Mountain Apache Tribal RBHA

Provider Enclosures

Enclose the following with this application: (***please check the box beside each document enclosed)***

__ copy of provider incorporation documents
__ copy of provider charter, if any
__ copy of Occupancy Permit for provider facility address
__ copy of an official current passing fire inspection
Fire inspection required every two years for renewal certification

Services Provided

Check all services below that your agency provides for which you request Title XIX Certification:

__ Transportation (see the ADHS/DBHS Covered Behavioral Health Services Guide for service codes)
__ Unskilled Respite S5150, S5151
__ Self-help/Peer Service (Individual - H0038, Group -H0038HQ)
__ Comprehensive Community Support Services (Peer Support) H2016
__ Support to Maintain Employment H2025, H2026
__ Supervised Behavioral Health Day Treatment H2012
__ Comprehensive Community Support (Supervised Day) H2015
__ Personal Care T1019 or T1020

[1] This is the service address where staff will be providing services. If staff will be providing services off-site at non-CSA facilities, please attach the list of off-site addresses (not including home addresses) where staff will be providing services.

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__ Home Care Training Family S5110
__ Psychoeducational Service H2027
__ Skills Training (Individual - H2014, Group - H2014HQ)
__ Psychosocial Rehabilitation H2017
__ BH Prevention/Promotion Education H0025

Check the following age groups for which your agency will be providing services:

____ 0-12 ____ 13-17 ____ 18 and older

CPR certificates for direct care staff and contractors must cover the age groups for which they will be providing services.

PROGRAM DESCRIPTION

Please describe the purpose, goals and objectives of the program, including the populations that will be served (i.e, children, SMI Adults).

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DIRECT SERVICE STAFF MEMBER/CONTRACTOR LIST

Name of Direct Service Staff Member or Contractor	Hire Date	CPR Certification Date	First Aid Certification Date	Fingerprint Clearance Card Date (if applicable)	Self Declaration of Criminal History Date (if applicable)	Services Provided BHP, BHT OR BHPP	Services Provided Must be BHP, BHT or BHPP with one year experience in providing rehabilitation services to persons with disabilities	Services Provided Must be BHP or BHT
						__Transportation __Unskilled Respite __Self Help/Peer Service __Peer Support __Supervised Behavioral Health Day Treatment __Supervised Day __Personal Care __Home Care Training Family __Skills Training __Psychosocial Rehabilitation	__Support to Maintain Employment __Psychoeducational Service	__BH Prevention/ Promotion Education
						__Transportation __Unskilled Respite __Self Help/Peer Service __Peer Support __Supervised Behavioral Health Day Treatment __Supervised Day __Personal Care __Home Care Training Family __Skills Training __Psychosocial Rehabilitation	__Support to Maintain Employment __Psychoeducational Service	__BH Prevention/ Promotion Education
						__Transportation __Unskilled Respite __Self Help/Peer Service __Peer Support __Supervised Behavioral Health Day Treatment __Supervised Day __Personal Care __Home Care Training Family __Skills Training __Psychosocial Rehabilitation	__Support to Maintain Employment __Psychoeducational Service	__BH Prevention/ Promotion Education

I attest that the staff members listed above will be providing only the services indicated on this form.

____ ______________

Signature of Program Director Date

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Name of direct service staff or contractor: ______________________________________

Direct Service Staff/Contractor Checklist

Complete the Direct Service Staff/Contractor Checklist for each direct service staff member or contractor listed

Name of provider: ____

Location(s) where staff will be providing services (if staff member or contractor will be providing services at more than one location): ______________________________________

Attach all credible evidence/documentation to this form

- ☐ Credible proof of age 18 or older/age 21 or older (See Exhibit 2 of Policy MI 5.2, Community Service Agencies – Title XIX Certification for requirements related to specific services. Credible evidence can consist of a birth certificate, baptismal certificate, or other picture ID containing a birth date, signed and dated by the staff member or contractor such as military identification, state ID card, or valid driver's license.)
- ☐ Reference form
- ☐ Copy of current driver's license (if providing transportation services)
  - ☐ Copy of current vehicle registration (for vehicle used to provide transportation services)
  - ☐ Copy of current liability insurance as required by A.R.S. 28-4009 (for vehicle used to provide transportation services)
- ☐ Credible evidence of meeting the requirements of a behavioral health professional, behavioral health technician or behavioral health paraprofessional (Credible evidence can consist of a copy of the license for the behavioral health professional, copies of the license or certificate and/or education/training/experience verification for the behavioral health technician, or copies of the high school equivalency diploma (completion of GED) or high school diploma or associates degree for the behavioral health paraprofessional. Unofficial transcripts will not be considered as credible evidence.)
- ☐ Credible evidence of one year work experience in providing rehabilitation services to persons with disabilities, if providing Ongoing Support to Maintain Employment and/or Psychoeducational Services (Credible evidence must be specific and clear documentation, indicating location and dates of staff or contractor's experience).
- ☐ Copy of Fingerprint Clearance Card, if providing services to persons under the age of 18 years (If a fingerprint clearance card has not been recently obtained, the provider is strongly encouraged to contact the Department of Public Safety, Fingerprinting Division, to ensure that the card is valid. As per A.R.S. § 41-1758.05, a person who knowingly falsifies a material fact or who makes or uses a false fingerprint clearance card knowing the false fingerprint clearance card contains a false, fictitious or fraudulent statement is guilty of a class 3 misdemeanor. If a direct service staff member is continuously employed or contracted with a CSA that provides services to persons under 18 years of age, the fingerprint clearance card must be obtained every six years - Department of Public Safety: http://www.azdps.gov. Application packets for initial or renewal of fingerprint clearance cards may be obtained by calling the Department of Public Safety, Fingerprinting Division, at (602) 223-2279or faxing the request for an application to (602) 223-2947.)
- ☐ Copy of DPS Form 802-06857 Applicant Fingerprint Clearance Card Application and copy of the completed and notarized State of Arizona Criminal History Affidavit form, if providing services to persons under the age of 18 years and does not have a Fingerprint Clearance Card (Application packets for initial or renewal of fingerprint clearance cards may be obtained by calling the Department of Public Safety, Fingerprinting Division, at (602) 223-2279or faxing the request for an application to (602) 223-2947.)
- ☐ Copy of the completed and notarized ADHS/DBHS Self-Declaration of Criminal History form, if providing services to persons age 18 and older.
- ☐ Copy of current Cardiopulmonary Resuscitation (CPR) Certificate signed by the instructor (If the CPR Certificate provided indicates that it is valid for infants/children, it will be accepted for staff and contractors who are only working with persons under the age of 18. If the CPR Certificate indicates that it is valid for adults, it will be accepted for staff and contractors who

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Name of direct service staff or contractor: ____

are only working with persons aged 18 and older.)
☐ Copy of First Aid training verification signed by the instructor
☐ Credible evidence of current freedom from infectious pulmonary tuberculosis (Signed and dated letter or report from a qualified medical practitioner administering the test and reading the results. Results must clearly indicate that the qualified medical practitioner determines that the direct service staff member or contractor is medically safe to provide services. Credible documentation shall be dated at the start of employment or prior to providing behavioral health services and every 12 months thereafter.)

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Name of direct service staff or contractor: ____

Direct service staff and contractors must complete all trainings listed below ***prior to providing direct services to behavioral health recipients***. Credible evidence of training must clearly indicate to reviewers of the application that direct service staff or contractors have received training in the specified content areas (i.e., training with different titles must be matched up to the trainings listed below).

Training Content	Date of Completion	Name of Person/Organization that provided training
Client rights		
Providing services in a manner that promotes client dignity, independence, individuality, strengths, privacy and choice		
Recognizing common symptoms of and differences between a mental disorder, personality disorder, and/or substance abuse		
Protecting and maintaining confidentiality of client records and information		
Record keeping and documentation		
Ethical behavior such as staff and client boundaries and the inappropriateness of receiving gratuities from a client		
Recognizing, preventing or responding to a client who may be a danger to self or a danger to others; behave in an aggressive or destructive manner; need crisis services or be experiencing a medical emergency		

Signatory Information

By signing below, I affirm under penalty of law that the information provided on this form is true, accurate, and complete to the best of my knowledge.

____ ______________________
Signature of Provider Director/Title Date

By signing below, I affirm that the information provided has been reviewed for completeness and accuracy.

____ ______________________
Signature of T/RBHA Reviewer Date

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Community Service Agency Title XIX Certification Initial Application Instructions

Complete all sections of the application form and enclose all required forms, certifications, permits, inspections, and documents with the application form. Documents that are purchased online and are not obtained through the applicable authority will not be considered as official or credible documentation.

The provider Director signs and dates the application form and indicates his/her title on the form.

The completed application is mailed or hand delivered to the T/RBHA with which the provider plans to contract.

Community Partnership of Southern Arizona	535 N. Wilmot, Suite 201 Tucson, AZ 85711
Cenpatico Behavioral Health of Arizona	1501 W Fountainhead Corporate Park Suite 295 Tempe, Arizona 85280
Northern Arizona Regional Behavioral Health Authority	1300 S. Yale Street Flagstaff, Arizona 86001
Magellan of Arizona	4129 E. Van Buren Street, Suite 250 Phoenix, Arizona 85008
Gila River Tribal Community	Department of Health Services Behavioral Health Care Clinic/RBHA P.O. Box 38 Sacaton, Arizona 85247
The Navajo Nation	P.O. Box 2505 Window Rock, Arizona 86515
Pascua Yaqui Tribe	Pascua Yaqui Tribal RBHA 7474 South Camino DeOeste Tucson, Arizona 85757
White Mountain Apache Tribe	PO Box 1089 249 W. Ponderosa Drive Whiteriver, AZ 85941

The T/RBHA reviews the proposed provider's application for completeness, and the T/RBHA reviewer signs the application. Once it is determined that the application is complete, the T/RBHA forwards the completed application packet to:

Arizona Department of Health Services
Division of Behavioral Health Services
Attention: Policy Office
150 N. 18th Avenue, Suite 260
Phoenix, Arizona 85007