

**ARIZONA DEPARTMENT OF HEALTH SERVICES  
DIVISION OF BEHAVIORAL HEALTH SERVICES**

NAME OF DIRECT SERVICE STAFF/CONTRACTOR: \_\_\_\_\_

**Community Service Agency Title XIX Certification**

**DIRECT SERVICE STAFF/CONTRACTOR REFERENCE FORM**

The following individuals have knowledge about all of the following: employment history, education and character of the direct service staff or contractor. Individuals giving references cannot be family members of the direct service staff or contractor.

<b>(1)</b>	
a). Name of Person Providing Reference:	b). Relationship of person to Direct Service Staff/Contractor and number of years/months that person has known Direct Service Staff/Contractor:  _____ (relationship) _____ (years/months)
c). Address: Street: _____ City: _____ State: _____ Zip: _____ Phone Number: _____ Verified by: _____	
<b>(2)</b>	
a). Name of Person Providing Reference:	b). Relationship of person to Direct Service Staff/Contractor and number of years/months that person has known Direct Service Staff/Contractor:  _____ (relationship) _____ (years/months)
c). Address: Street: _____ City: _____ State: _____ Zip: _____ Phone Number: _____ Verified by: _____	
<b>(3)</b>	
a). Name of Person Providing Reference:	b). Relationship of person to Direct Service Staff/Contractor and number of years/months that person has known Direct Service Staff/Contractor:  _____ (relationship) _____ (years/months)
c). Address: Street: _____ City: _____ State: _____ Zip: _____ Phone Number: _____ Verified by: _____	

By signing this form, I affirm that the three references have been contacted to provide information regarding the employment history, education and character of the Direct Service Staff/Contractor.

\_\_\_\_\_  
*Program Director Signature*

\_\_\_\_\_  
*Date*