

**Arizona Department of Health Services/Division of Behavioral Health Services
COMMUNITY SERVICE AGENCY TITLE XIX CERTIFICATE**

TYPE OF ACTION (CIRCLE): 1. Initial Certificate 2. Renewal Certificate 3. Amended Certificate	FACILITY NAME, PROGRAM DIRECTOR AND ADDRESS: _____ _____ _____
Certification Effective Date: _____ Renewal Date: _____ Amended Date: _____	

Services Being Provided (check all that apply):

Transportation

TIER I:

Unskilled Respite

Self-help Peer Service or Comprehensive Community Support Services (Peer Support)

Personal Care

Support to Maintain Employment

Psychoeducational Service .

TIER II:

Home Care Training Family

Skills Training or Psychosocial Rehabilitation

Supervised Day or Comprehensive Community Support (Supervised Day Program)

Behavioral Health Prevention/Promotion Education

Title XIX

Community Service Agency

RBHA/TRBHA AFFILIATION (check all that apply):

CPSA-3	Cenpatico-4
CPSA-5	NARBHA
Cenpatico-2	Magellan
Gila River	Navajo Nation
Pascua Yaqui	White Mountain Apache Tribe

TITLE XIX CERTIFICATION ACTION:

Approved _____ **Expiration Date:** _____/_____/_____

Certification Number _____

Authorized ADHS/DBHS Signature _____ Signature and Title	AHCCCS Provider Type A3 Community Service Agency
_____ Date	

A copy of this Certificate must be sent with the Provider Registration Packet when registering with the Arizona Health Care Cost Containment System –(AHCCCS), and a copy of this Certificate must be sent to AHCCCS when it has been amended.