Behavioral Health Provider Certification and Transmittal Request

Select License Subclass:

◯ Adult Behavioral Health Therapeutic Home
◯ Behavioral Health Residential Facility
◯ Behavioral Health Respite Home

Facility License Number: _____ **Facility Capacity/Occupancy:** _____

Facility Physical Address: _____

City: _____ **AZ** **Zip Code:** _____

>Does the licensee currently have a 'Certification and Transmittal'? ◯ Yes or ◯ No
If yes, certification effective date: _____

>Is the health care institution requesting certification under Title XIX of the Social Security Act?
◯ Yes or ◯ No
If yes, requested effective date: _____

>Is the health care institution accredited? ◯ Yes or ◯ No
If yes, name of the accrediting organization: _____
Accreditation period: _____ to _____

_____ _____
Print name of requestor Signature of requestor

To be completed by ADHS staff

Licensure Period: _____ *To:* _____

Accreditation Period: _____ *To:* _____

Select one:

◯ *Re-certification*
◯ *New certification*