

ARIZONA DEPARTMENT OF HEALTH SERVICES  
DIVISION OF BEHAVIORAL HEALTH SERVICES

Community Service Agency Title XIX Certification  
AMENDMENT

**Provider Information**

Please fill out all sections in the Provider Information portion of this form

Date of Application: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

AHCCCS Provider ID #: \_\_\_\_\_

National Provider Identification (NPI): \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Phone Number: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

Provider E-Mail Address: \_\_\_\_\_

Provider Administrative Address (if applicable):

City: \_\_\_\_\_ State: \_\_\_\_\_

Street \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

Provider Facility Address<sup>1</sup>:

City: \_\_\_\_\_ State: \_\_\_\_\_

Street \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

Provider Mailing Address:

City: \_\_\_\_\_ State: \_\_\_\_\_

Street \_\_\_\_\_

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.**

Cenpatico-3  Cenpatico-4

CPSA  NARBHA

Cenpatico-2  Mercy Maricopa Integrated Care

Navajo Nation  Gila River Tribal RBHA

Pascua Yaqui Tribal RBHA  White Mountain Apache Tribal RBHA

**Provider Enclosures**

If there has been a change in location of the CSA, please fill out the Provider Enclosures portion of this form

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 services that your agency will be adding, and check the age group(s) that your CSA will be serving, if the age group has changed.

- Transportation (see the ADHS/DBHS Covered Behavioral Health Services Guide for service codes)
- 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
- Home Care Training Family S5110

<sup>1</sup> 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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- 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**

*If the purpose, goals and/or objectives of the CSA have changed, please include an updated program description*

**ARIZONA DEPARTMENT OF HEALTH SERVICES  
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DIRECT SERVICE STAFF MEMBER/CONTRACTOR LIST FOR ADDED SERVICES**

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 <u>Must</u> be BHP, BHT or BHPP with one year experience in providing rehabilitation services to persons with disabilities	Services Provided <u>Must</u> be BHP or BHT
						<input type="checkbox"/> Transportation <input type="checkbox"/> Self Help/Peer Service <input type="checkbox"/> Peer Support <input type="checkbox"/> Supervised Behavioral Health <input type="checkbox"/> Day Treatment <input type="checkbox"/> Supervised Day <input type="checkbox"/> Personal Care <input type="checkbox"/> Home Care Training Family <input type="checkbox"/> Skills Training <input type="checkbox"/> Psychosocial Rehabilitation	<input type="checkbox"/> Support to Maintain Employment <input type="checkbox"/> Psychoeducational Service	<input type="checkbox"/> BH Prevention/ Promotion Education
						<input type="checkbox"/> Transportation <input type="checkbox"/> Self Help/Peer Service <input type="checkbox"/> Peer Support <input type="checkbox"/> Supervised Behavioral Health <input type="checkbox"/> Day Treatment <input type="checkbox"/> Supervised Day <input type="checkbox"/> Personal Care <input type="checkbox"/> Home Care Training Family <input type="checkbox"/> Skills Training <input type="checkbox"/> Psychosocial Rehabilitation	<input type="checkbox"/> Support to Maintain Employment <input type="checkbox"/> Psychoeducational Service	<input type="checkbox"/> BH Prevention/ Promotion Education
						<input type="checkbox"/> Transportation <input type="checkbox"/> Self Help/Peer Service <input type="checkbox"/> Peer Support <input type="checkbox"/> Supervised Behavioral Health <input type="checkbox"/> Day Treatment <input type="checkbox"/> Supervised Day <input type="checkbox"/> Personal Care <input type="checkbox"/> Home Care Training Family <input type="checkbox"/> Skills Training <input type="checkbox"/> Psychosocial Rehabilitation	<input type="checkbox"/> Support to Maintain Employment <input type="checkbox"/> Psychoeducational Service	<input type="checkbox"/> 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

**ARIZONA DEPARTMENT OF HEALTH SERVICES  
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Name of direct service staff or contractor: \_\_\_\_\_

**Direct Service Staff/Contractor Checklist**

**Complete the Direct Service Staff/Contractor Checklist for new staff who will be providing the additional services. If staff who will be providing the additional services have already been reviewed in previous applications, only provide documentation that is required to indicate that those staff are qualified to provide the additional services (see grey boxes below). If the purpose of this amendment application is to start providing services to persons under the age of 18, please provide the required documentation for a Fingerprint Clearance Card and CPR certificate.**

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) 223-2279 or 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) 223-2279 or 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.

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Name of direct service staff or contractor: \_\_\_\_\_

<input type="checkbox"/> 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 are only working with persons aged 18 and older.)
<input type="checkbox"/> Copy of First Aid training verification signed by the instructor
<input type="checkbox"/> 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.)

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

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

**Community Service Agency Title XIX Certification Amendment Instructions**

Complete all applicable sections of the amendment form and enclose all required forms, certifications, permits, inspections, and documents with the amendment 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 contracts.

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
Mercy Maricopa Integrated Care	4350 E. Cotton Center Blvd., Building D Phoenix, Arizona 85040
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 provider's amendment form 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. 18<sup>th</sup> Avenue, Suite 260  
Phoenix, Arizona 85007