QUARTERLY CERTIFICATION STATEMENT FROM

(Name of Tribal Contractor)

TO THE

Arizona Health Care Cost Containment System

FOR THE PERIOD ENDED

(Time Period)

Prepared by: **(Type name here)**

Title: **(Type title here)**

Phone Number: **(Type phone number here)**

I hereby attest that the information submitted in the reports herein is in compliance with the cost principals in OMB Circular A-87 and is current, complete, and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Tribal Contractor's agreement or contract with the Arizona Health Care Cost Containment System. Failure to sign a Certification Statement will result in AHCCCS' non acceptance of the attached reports.

(Preparers Signature)	(Date Signed)
(Approvers Signature)	(Date Signed)
(Approvers Signature)	(Date Signed)