

**ADHS/DBHS POLICY AND PROCEDURES MANUAL  
POLICY FORM 1102.1**

**QUARTERLY SHOWING REPORT CERTIFICATION**

I hereby certify that during the calendar quarter of (Month and Year) through (Month and Year) for each eligible person for whom capitation for health services from AHCCCS was received, there were methods and procedures to assure that:

1. A qualified team certified (and, where inpatient services were furnished over a period of time, re-certified) the necessity of inpatient services for each eligible person receiving such services through (name of T/RBHA).
2. In the case of each (name of T/RBHA) eligible person receiving inpatient services, such services were furnished under a plan of care established and periodically reviewed and evaluated by a qualified team.
3. There was in operation a continuous program of utilization review under which the admission of each eligible person receiving services was reviewed or screened.

Date: \_\_\_\_\_ T/RBHA Name: \_\_\_\_\_

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Printed Name \_\_\_\_\_ Title \_\_\_\_\_

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Signature \_\_\_\_\_ Date \_\_\_\_\_