

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Policy 961, Exhibit-6,

Community Service Agency Approval Notice

TYPE OF ACTION (CIRCLE): 1. Initial Application 2. Renewal Application 3. Amended Application	FACILITY NAME, PROGRAM DIRECTOR AND ADDRESS: <hr/> Initial Effective Date: _____ Renewal Date: _____ Amended Date: _____
Services Being Provided (check all that apply): TIER I: <input type="checkbox"/> Transportation <input type="checkbox"/> Self-help Peer Service or Comprehensive Community Support Services (Peer Support) <input type="checkbox"/> Personal Care <input type="checkbox"/> Support to Maintain Employment <input type="checkbox"/> Psychoeducational Service . TIER II: <input type="checkbox"/> Home Care Training Family <input type="checkbox"/> Skills Training or Psychosocial Rehabilitation <input type="checkbox"/> Supervised Day or Comprehensive Community Support (Supervised Day Program) <input type="checkbox"/> Behavioral Health Prevention/Promotion Education	
RBHA AFFILIATION (check all that apply): <input type="checkbox"/> Cenpatico Integrated Care <input type="checkbox"/> Health Choice Integrated Care <input type="checkbox"/> Mercy Maricopa Integrated Care AMERICAN INDIAN HEALTH PROGRAM: <input type="checkbox"/> Serving members through the American Indian Health Program, Fee for Service Program.	
TITLE XIX CERTIFICATION ACTION: Approved _____ Expiration Date: _____ / _____ / _____ Reference Number _____	
Authorized AHCCCS Signature _____ Signature and Title _____ Date	AHCCCS Provider Registration Number _____ A3 Community Service Agency _____

A copy of the Initial Approval Notice must be sent with the AHCCCS Provider Registration Packet.