



FIRST THINGS FIRST

ARIZONA EARLY CHILDHOOD THERAPIST INCENTIVES PROGRAMS SERVICE AREA APPLICATION

Mail completed *Therapist and Service Area Application(s)* to:



Arizona Department of Health Services
Bureau of Health Systems Development
Attn: FTF Early Childhood Therapist Incentives Program Manager
150 N 18th Avenue Suite 300
Phoenix, Arizona 85007

Please direct all inquiries to:
Ms. Cpc"N{p"Tquegwk MPJ
PH: 602-542-3288
FX: 602-542-2011

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****Be sure to include copies of requested additional information****

***First Things First (FTF)**, approved by Arizona voters, works to ensure that our youngest children have access to quality early childhood experiences so they will start school healthy and ready to succeed. Across the state, FTF regional partnership councils-in collaboration with local leaders-identify the educational and health needs of children from birth through age 5 in their communities and fund strategies to address those needs. FTF works with those impacting the early childhood experience-including parents and other caregivers, government agencies, community organizations, health care providers and educators-to make the most efficient and effective use of Arizona’s early childhood resources.

Assurances of Employer or Therapy Clinic Eligibility (for executive director/manager's initials):

_____A. This employer or therapy clinic is in compliance with the FTF Early Childhood Therapist Incentives Programs eligibility requirements.

To be eligible to have a therapist participate, an employer or therapy clinic shall:

1. Provide services in acceptable regional council zip code(s);
2. Accept DES/AzEIP, DES/DDD, AHCCCS, or Local Education Agency caseload assignments and rates;
3. Certify that the employer or clinic site will not practice or permit discrimination on the basis of race, color, gender, national origin, age, religion, creed, disability, veteran's status, sexual orientation, gender identity or gender expression.

_____B. This employer or therapy clinic has an employment agreement or contract with the therapists that covers or will cover the period of obligation applied for, and has the financial means available to support the therapist that may include salary, benefits, and malpractice insurance expenses for a minimum of 24 months.

I hereby certify that, to the best of my knowledge, the information contained in this application is accurate, and hereby authorize the Arizona Department of Health Services or its designee to verify all information presented.

Typed or Printed Name of Executive Director/Manager: _____
(where applicable)

Signature of Executive Director/Manager: _____ Date: _____

State of 'aaaaaaaaaaaaaaaaaaaa')
.....+
County of 'aaaaaaaaaaaaaaaaaaaa')

The foregoing instrument was acknowledged before me this _____ day of _____

_____ My Commission Expires: _____
Notary Public

WARNING: Any person who knowingly makes a false statement or misrepresentation or material omission in this loan repayment application, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to a fine or imprisonment. I have read this statement and understand its contents.

(Initials of Executive Director/Manager)