



# FIRST THINGS FIRST

## ARIZONA EARLY CHILDHOOD THERAPIST INCENTIVES PROGRAMS **THERAPIST 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 18<sup>th</sup> Ave Suite 300  
Phoenix, Arizona 85007

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

**Only complete applications meeting program eligibility will be considered for a State contract.  
Please allow 10 weeks for application processing.**

Please direct all inquiries to:  
**Ana Lyn Roscetti, MPH**  
Workforce Section Manager  
(602) 542-1066  
(602) 542-2011 (fax)  
[ana.lyn.roscetti@azdhs.gov](mailto:ana.lyn.roscetti@azdhs.gov)

**\*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.

**PROVIDER CHECKLIST**

**The following documents must be submitted:**

- Provider application (notarized)
  - Service application(s) (notarized)
  - Substitute W-9 form (<http://ftfincentives.com/FTFappProcess.htm>)
  - Copy of the Procure AZ registration receipt from <https://procure.az.gov/bsol/>
  - Copy of Social Security card
  - Copy of birth certificate, U.S. Passport, or naturalization papers
  - Copy of current resume
  - Copy of Arizona license(s)
  - Copy of diplomas/educational certificate(s)
  - Copy of certificate(s) of specialized training, additional certifications, or acceptance letter from authorizing/accrediting agency
  - Copy of employment contract that includes the following:
    - Name and address of employer (if other than the service site)
    - List of zip codes or the address of clinic site where services are to be provided
    - A minimum of 30 hours per week of services to children birth through age 5
    - Scope of services
    - A minimum of 24 month duration of contract (for initial contract) or intent to renew employment for the duration of the state contract

**Note:** If an employment contract is not available, a notarized employer letter certifying meeting the above requirements may be submitted in lieu of the employment contract.
  - Copy of the employer’s contract or signature page of the vendor agreement with DES/AzEIP, DES/DDD, AHCCCS, or Local Education Agency
  - Loan verification from lending institution, p. 7 (**original signature is required**)
  - Copy of most recent billing statement(s) for each loan to be repaid
- Note: Up to 3 loans are acceptable for payment.
- 

**How Did You Find Out About This Program?**

- \_\_\_\_\_ Program Flyer
- \_\_\_\_\_ Web search
- \_\_\_\_\_ Employer
- \_\_\_\_\_ School/College Financial Aid Office
- \*\*\*\*\* School Faculty
- \_\_\_\_\_ Friend
- \_\_\_\_\_ Professional Organization (Please specify) \_\_\_\_\_
- \_\_\_\_\_ Other (Please specify) \_\_\_\_\_

# ARIZONA EARLY CHILDHOOD THERAPIST PROGRAMS THERAPIST APPLICATION

## IMPORTANT!

You may be eligible to receive both Loan Repayment and Stipend depending on the region where you will provide therapy services. To verify your eligibility, please check:"

[j vr <ly v y @| f j ul qx lj uf 1bhlHVHt gi kqpu fj vo](#)

Please check the program(s) you wish to be considered.

Loan Repayment

Stipend

---

## SECTION I. PERSONAL INFORMATION

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please send copy of Social Security card) (Month/Day/Year)

U. S. Citizen? Yes \_\_\_\_\_ No \_\_\_\_\_ Other: \_\_\_\_\_  
Please attach a copy of your birth certificate, a U.S. passport, or naturalization papers.

Home Address \_\_\_\_\_  
(Number) "" (Street) (Apt Number)  
\_\_\_\_\_  
(City) (State) (Zip)

E-mail address: \_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_ Daytime: \_\_\_\_\_

Languages You Speak Fluently: \_\_\_\_\_ English  
\_\_\_\_\_ Spanish  
\_\_\_\_\_ Native American (Specify which language) \_\_\_\_\_  
\_\_\_\_\_ Other (Specify) \_\_\_\_\_

Discipline/Degree: \_\_\_\_\_ Speech Therapist (Masters Level) \_\_\_\_\_ Child Psychologist  
\_\_\_\_\_ Physical Therapist \_\_\_\_\_ Occupational Therapist  
\_\_\_\_\_ Mental Health Specialist  
Please specify degree: \_\_\_\_\_

Name of the First Things First Regional Council and zip code(s) in which the services will be rendered:

Find your local council: <http://www.azftf.gov/Pages/default.aspx>

Are you a NEW therapist as specified under the eligibility criteria at [www.ftfincincentives.com](http://www.ftfincincentives.com)? \_\_\_Y \_\_\_N  
If YES, please specify? \_\_\_\_\_

**SECTION II. EDUCATION AND CERTIFICATIONS**

**\*\*PLEASE PROVIDE COPIES OF ALL LICENSES, CERTIFICATES, AND A CURRENT RESUME\*\***

**A. Identify the professional school from which you received your professional degree/certificate.**

Name of School: \_\_\_\_\_

Location of School: \_\_\_\_\_  
(City) (State)

In what year did begin your work for this degree/certificate: \_\_\_\_\_

In what year did you receive this degree/certificate: \_\_\_\_\_

**B. Post-Graduate Professional Training:**

Have you completed a graduate program? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide the following information:

\_\_\_\_\_  
(Name of Program)

\_\_\_\_\_  
(City) (State)

Begin Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
(Month/Year) (Month/Year)

**C. Undergraduate Education:**

Name of School: \_\_\_\_\_

Location of School: \_\_\_\_\_  
(City) (State)

Degree \_\_\_\_\_ Major (Area of Concentration) \_\_\_\_\_

Begin Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
(Month/Year) (Month/Year)

**D. Licensing/Certification:**

Are you currently holding a permanent license in the State of Arizona? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, when do you plan to take the examination for licensure? \_\_\_\_\_

Do you hold a license in any state other than Arizona? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the following information:

State of Licensing: \_\_\_\_\_ License Number: \_\_\_\_\_

Date of Original Licensure: Start: \_\_\_\_\_ Current Expiration: \_\_\_\_\_

Please describe any license restrictions: \_\_\_\_\_

**Please list all certifications relevant to this application:**

Type of Certificate: \_\_\_\_\_

State of Certification: \_\_\_\_\_ "Certificate Number: \_\_\_\_\_

Date of Original Certification: \_\_\_\_\_ "Current Expiration: \_\_\_\_\_

Type of Certificate: \_\_\_\_\_

State of Certification: \_\_\_\_\_ "Certificate Number: \_\_\_\_\_

Date of Original Certification: \_\_\_\_\_ "Current Expiration: \_\_\_\_\_

Other Certifications: \_\_\_\_\_

Please describe any certification restrictions: \_\_\_\_\_  
\_\_\_\_\_

**\*If not yet certified, please send a copy of your acceptance letter from the examining authority.\***

**SECTION III. EXISTING OR PRIOR COMMITMENTS**

- Do you have an existing professional service obligation to a Federal, State, or other entity? \*\*\* Yes \_\_\_\_\_ No \_\_\_\_\_

\*\*\* Other professional service obligations and delinquent status, federal judgment liens, or professional default may preclude an applicant from being eligible for the LRP unless that service obligation will be completely satisfied before the contract has been signed.

If yes, Name of Program: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Telephone Number: \_\_\_\_\_

Complete Contact Address: \_\_\_\_\_  
\_\_\_\_\_

Terms of obligation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Are you delinquent on any financial obligation (i.e., taxes, student or home mortgage loans or child support)? Yes \_\_\_\_\_ No \_\_\_\_\_
- Are you subject to any judgment liens for a federal debt to the United States? Yes \_\_\_\_\_ No \_\_\_\_\_
- Are you in default of any professional service obligation? \*\*\*\* Yes \_\_\_\_\_ No \_\_\_\_\_

\*\*\*\* e.g. have you failed to begin or complete service or failed to fulfill service requirements.

If yes, Name of Program: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Telephone Number: \_\_\_\_\_

Complete Contact Address: \_\_\_\_\_  
\_\_\_\_\_

Terms of obligation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION IV. SERVICE SITE or EMPLOYER COMMITMENT**

Attach a copy of the signed employment contract for the current or prospective service site/employer. Contract must include the work hours, scope of services, **and that services will be delivered as contracted through an approved service site for a minimum of 24 months.**

Service Area/Zip Code(s): \_\_\_\_\_

Service under the employment contract is to commence on \_\_\_\_\_ and end on \_\_\_\_\_

Name of Regional Council: \_\_\_\_\_

**SECTION V. LOAN INFORMATION**

**(Please go to section VII if only applying for the Stipend Program)**

Please copy and complete this form for each loan you wish to have repaid under the Arizona First Things First Early Childhood Therapist Incentives Program, Loan Repayment component. This form must be sent to each of your lenders for verification. If more than one loan, please indicate any preference you may have for repayment. There is a limit of three lenders that will be repaid per contract. Please send a copy of your most recent billing notice for documentation.

1. Applicant's Name (Last, First, Middle) \_\_\_\_\_ 2. Applicant's Social Security No. \_\_\_\_\_

3. Applicant's Complete Address \_\_\_\_\_ 4. Applicant's Telephone No. \_\_\_\_\_

5. (Name of Lending Institution) \_\_\_\_\_ 6. Loan Account No. \_\_\_\_\_

7. Full Address of Lending Institution \_\_\_\_\_ 8. Lender Institution Telephone No. \_\_\_\_\_

9. Was the loan sold? (If you are not sure, check with your lender) If "yes," give the secondary loan holder's name and full address. Yes \_\_\_\_\_ No \_\_\_\_\_

10. Original Date of Loan: \_\_\_\_\_ 11. Original Amount of Loan: \$ \_\_\_\_\_

12. Current Balance (Principal & Interest): \$ \_\_\_\_\_ as of (date) \_\_\_\_\_ Interest Rate \_\_\_\_\_ %

13. Purpose of loan as Indicated on the Loan Application: \_\_\_\_\_

14. Type of Loan: \_\_\_\_\_

15. Loan in Default? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Default: \_\_\_\_\_

16. Is loan under a Federal Court Judgment? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Judgment \_\_\_\_\_

\*\*\*\*\*

**FOR CONSOLIDATED UNDERGRADUATE AND GRADUATE EDUCATION LOANS** – If undergraduate and graduate education costs have been consolidated, attach a copy of the loan documents for health professions education costs that were consolidated into the new loan.

**Certification by Applicant Borrower and Release of Loan Information**

I hereby certify to the accuracy of the above information and apply to enter into an agreement with the State of Arizona for repayment of all or the appropriate portion of the educational loan(s) listed in Section VII herein. I further certify that this/these loan(s) were incurred solely for the costs of health professional education, including reasonable living expenses. I hereby authorize the lender, be it government or financial institution, named in Section VII to release information about the loan(s) listed in Section VII to the administrators of the Arizona FTF Early Childhood Therapist Incentives Program, Loan Repayment component.

Legal Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number of Applicant: \_\_\_\_\_

\*\*\*\*\*

**Lending Institution's Certification**

The undersigned states that, to the best of his or her knowledge, the loan identified in Section VII is a bona fide and legally enforceable commercial, state, or government educational loan made for the purpose of meeting the borrower's costs of attending undergraduate school or graduate school in a health profession.

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

**Government/State or Bank Authorized Official**

Title: \_\_\_\_\_

**SECTION VI. CERTIFICATION (Loan Repayment)**

1. I hereby certify that, to the best of my knowledge, the loan(s) identified in this application is/are educational loan(s), incurred solely for the costs of undergraduate or graduate education, including reasonable living expenses, leading to a degree in the health profession and specialty indicated in Section I of this application; and that the loan amounts do not reflect consolidated loans for other purposes.
2. I hereby certify that I am applying to enter into a contract with the state of Arizona for repayment of all or part of the educational loan(s) listed in this application.
3. I hereby certify that I will provide at least 30 hours of obligated service per week to children birth through age 5 to be eligible for program participation.
4. I hereby certify that I will accept DES/AzEIP, DES/DDD, AHCCCS, or Local Education Agency caseload assignments and rates.
5. I hereby certify that I 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.

**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 applicant)

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

Typed or Printed Name: \_\_\_\_\_

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

State of \_\_\_\_\_ )

County of \_\_\_\_\_ )

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
Notary Public My Commission Expires: \_\_\_\_\_

**SECTION VII. STIPEND**

Per Participating FTF Regional Council funding availability

Moving Expenses	Sign On Bonus	12 Month** Service Completion	24 Month **Service Completion	Professional Affiliations & Licensure	Additional Incentives (CEUs***, Professional Memberships, Webinars, Etc.)
Up to \$3,000	\$3,000	\$5,000	\$7,500	Not to exceed \$500	Up to \$2,500

\*Provider requesting reimbursement certifies that these expenses are not being reimbursed by another entity and **will not be submitted for reimbursement by any other entity.**

\*\* Provider cannot be away from post for more than 35 days to be in contract compliance for obligated service time.

\*\*\*Reimbursement is provided for the actual cost of the Continuing Education Units (CEU). **No travel costs including air and hotel associated with the CEU will be covered by this reimbursement.**

**Please attach original receipts for actual moving expenses and Stipend Request Form.**

**Please attach confirmation of year(s) of service by submitting a completion letter by agency where services were rendered (e.g. AZ/EIP, DDD, AHCCCS, Local Education Agency)**

**SECTION VIII. CERTIFICATION (Stipend)**

1. I hereby certify that, to the best of my knowledge, the information contained in this application is accurate and authorize the Arizona Department of Health Services or its designee to verify all information presented.
2. I hereby certify that I am applying to enter into a contract with the state of Arizona for participation in the Arizona First Things First Stipend Program and/or request disbursement of all or part of the allowable stipend(s) listed in this application per program determination.
6. I hereby certify that I will provide at least 30 hours of obligated service per week to children birth through age 5 to be eligible for program participation.
7. I hereby certify that I will accept and continue to accept DES/AzEIP, DES/DDD, AHCCCS, or Local Education Agency caseload assignments and rates.
8. I hereby certify that I 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.

***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 applicant)

Typed or Printed Name: \_\_\_\_\_

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

State of \_\_\_\_\_ )

\_\_\_\_\_ )

County of \_\_\_\_\_ )

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
Notary Public My Commission Expires: \_\_\_\_\_