

Arizona Department of Economic Security  
Rehabilitation Services Administration  
Disability Related Employment Services  
CLIENT SERVICE PLAN

**Section I: Basic Information**

Date of Service Plan Meeting:	
Client Name:	
Client's Guardian/Representative (if applicable):	
Contractor Name/Contractor Representative:	
Contract Number:	Authorization Number:
VR Counselor:	

**Section II: Client Preferences**

Service: <input type="checkbox"/> Employment Services <input type="checkbox"/> Supported Employment Services <input type="checkbox"/> Revision Date:	
Anticipated Start Date:	Anticipated Hours per Month:
Client's Vocational Goal:	
Work Preferences (full time/part time, hours, etc.):	
Specific barriers to employment:	
Accommodations needed in the workplace:	
Additional Comments:	

Arizona Department of Economic Security  
 Rehabilitation Services Administration  
 Disability Related Employment Services  
 CLIENT SERVICE PLAN

**Section III: Employment Services**

<input type="checkbox"/> Teach skills necessary for client to: <ul style="list-style-type: none"> <li>• Develop resume, cover letter, and separate reference list which are accurate, grammatically correct, and typed.</li> <li>• Complete applications either online or hardcopy</li> <li>• Utilize various job search websites, including but not limited to, registering on each site, filtering for specific career outcomes, uploading documents, etc.</li> </ul>
<input type="checkbox"/> Ensure client contact information such as email, phone contact(s) and voicemail is professional and appropriate;
<input type="checkbox"/> Complete mock interviews to develop interview skills;
<input type="checkbox"/> Specific to IPE employment goal, develop job sites, complete work site analysis for needed accommodations, conduct direct job placements, etc.;
<input type="checkbox"/> Assist client in actively seeking employment opportunities; speaking with potential employers, obtaining and completing applications, and increasing networking opportunities;
<input type="checkbox"/> Monitor the client's progress and provide ongoing support and feedback throughout the provision of Employment Services.
Referral is: <input type="checkbox"/> Accepted <input type="checkbox"/> Declined (please explain):

**Section IV: Signatures**

By signing this form:

- The client and/or their guardian/representative, the Contractor and the Counselor, agree to work together as a team to achieve the client's successful employment specified in this document;
- The Client and/or their guardian/representative, confirm that they fully understand the following:
  1. The Client needs to be actively involved and working toward successful employment.
  2. The impact of employment on their SSI/SSDI benefits, and that it is their responsibility to report their earnings to the Social Security Administration (SSA) each month.

Client:	Date:
Client Guardian/Representative (if applicable):	Date:
VR Counselor:	Date:
Contractor Representative:	Date:

Arizona Department of Economic Security  
 Rehabilitation Services Administration  
 Disability Related Employment Services  
 MONTHLY PROGRESS REPORT

**Instructions:** Complete Section I: Basic Information, Section II: Progress Reporting, and Section IV: Signatures monthly. Write 3 months of consecutive progress notes on each Client Monthly Progress Report. Submit entire report with every invoice. Complete Section III Employment Placement Information and submit to counselor within 5 days of client employment.

**Section I: Basic Information**

Client Name:	
Contractor Name/Contractor Representative:	
Contract Number:	Authorization Number:
VR Counselor:	

**Section II: Progress Reporting**

1. Teach skills necessary for client to:
  - Develop resume, cover letter, and separate reference list which are accurate, grammatically correct, and typed.
  - Complete applications either online or hardcopy
  - Utilize various job search websites, including but not limited to, registering on each site, filtering for specific career outcomes, uploading documents, etc.
2. Ensure client contact information such as email, phone contact(s) and voicemail is professional and appropriate;
3. Complete mock interviews to develop interview skills;
4. Specific to IPE employment goal, develop job sites, complete work site analysis for needed accommodations, conduct direct job placements, etc;
5. Assist client in actively seeking employment opportunities, speaking with potential employers, obtaining and completing applications, and increasing networking opportunities
6. Monitor the client's progress and provide ongoing support and feedback throughout the provision of Employment Services.

Month	Describe client progress in achieving service plan objectives including obtained and/or improved skills, activities engaged in, tasks completed, and client feedback provided. Identify any barriers/concerns/recommendations. Include hours and dates of service.	Total Billable Hours

**Section III: Employment Placement Information**

Date of Placement:
Employer Name:
Employer Address:

Arizona Department of Economic Security  
 Rehabilitation Services Administration  
 Disability Related Employment Services  
 MONTHLY PROGRESS REPORT

Employer Phone:
Job Title:
Job Duties:
Job Modifications/Accommodations:
Hours per week:
Rate of Pay (please specify if pay rate is: hourly/ weekly/ bi-weekly/ or monthly):
Benefits Available: <input type="checkbox"/> Medical <input type="checkbox"/> Sick Leave <input type="checkbox"/> Vacation <input type="checkbox"/> Retirement/Pension Plan
Are the wages and level of benefits comparable to that paid by the employer for same or similar work performed by individuals without disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No (explain)

**Section IV: Signatures**

Contractor Month 1:	Date:
Contractor Month 2:	Date:
Contractor Month 3:	Date:

Arizona Department of Economic Security  
 Rehabilitation Services Administration  
 Disability Related Employment Services  
**SERVICE CLOSURE REPORT**

**Section I: Basic Information**

Client Name:	
Contractor Name/Contractor Representative:	
Contract Number:	Authorization Number:
VR Counselor:	

**Section II: Successful Service Closure Information**

Date of Service Closure:
Client achieved: <input type="checkbox"/> Successful Employment Outcome <input type="checkbox"/> Successful Supported Employment Outcome
Employer Name:
Job Title:
Job Duties:
Hours per week:
Rate of Pay:
Benefits Available: <input type="checkbox"/> Medical <input type="checkbox"/> Sick Leave <input type="checkbox"/> Vacation <input type="checkbox"/> Retirement/Pension Plan
Client is taking advantage benefits: <input type="checkbox"/> Medical <input type="checkbox"/> Sick Leave <input type="checkbox"/> Vacation <input type="checkbox"/> Retirement/Pension Plan

**Section III: Unsuccessful Service Closure Information**

<input type="checkbox"/> Client was not satisfied with the service provision and requested another contractor <input type="checkbox"/> Client moved out of service area <input type="checkbox"/> Client dropped out of services due to health issues <input type="checkbox"/> Client was incarcerated <input type="checkbox"/> Contractor lost contact with the client <input type="checkbox"/> Client circumstances have changed and they no longer wish to pursue employment services <input type="checkbox"/> Contractor can no longer serve client due to organization or business changes <input type="checkbox"/> Contractor no longer willing to work with client <input type="checkbox"/> RSA determined services were no longer appropriate <input type="checkbox"/> Other reason for closure (specify):
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**Section IV: Signatures:**

Contractor Representative:	Date:
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## Exhibit D

### Code of Conduct

The Contractor shall adhere to the following Code of Conduct:

- 1.0 Subcontract with or recommend only those individuals or organizations that are culturally sensitive, who meet accessibility standards for the disabled, and who do not discriminate based on ethnicity, gender, age, race, religion, marital status, sexual orientation, or socioeconomic status. Subcontractors and their credentials need to be approved by RSA Central Office prior to providing services under this contract.
- 2.0 The Contractor, its personnel, subcontractors and any other individuals on the Contractor's premises shall:
  - 2.1 Represent himself/herself accurately to RSA clients and shall not mislead the clients regarding the Contractor's relationship with ADES/RSA, or mislead the clients regarding the Contractor's skills, capabilities or credentials.
  - 2.2 Collaborate with RSA Counselors or RSA designated representatives and other service providers (if applicable) in the best interest of the clients and, to the extent possible, avoid disagreements that might have adverse effects on the clients. When collaborating with other community agencies that serve the same client(s), abide by the decisions that were agreed upon by all of the involved parties and assist in implementing such decisions which are consistent with applicable laws, regulations, rules and policies.
  - 2.3 Ensure at all times that client information is used only for the purpose of fulfilling contractual responsibility and is not released to any other individual, agency, or organization. Confidential information and reports obtained, purchased, and paid for under this contract shall never be shared without the expressed permission from the RSA client and the RSA Counselor or RSA designated representative assigned to the client case.
  - 2.4 Develop and maintain a confidentiality policy statement and establish procedures that restrict access to confidential client records and information. This provision shall not be construed to limit the right of RSA staff or other authorized representative(s) to access client case records and information pertinent to the provision of the contracted service.
  - 2.5 Ensure that RSA clients are safeguarded and supervised by the Contractors' personnel assigned to provide the contracted service at all times when on the Contractor's premises.
  - 2.6 Always act in a professional manner, honor commitments, treat RSA clients with respect, dignity, and courtesy, and project a positive attitude.
  - 2.7 NEVER:
    - 2.7.1 Engage in any form of intimate and sexual activity with an RSA client.
    - 2.7.2 Enter into any business partnership with an RSA client.
    - 2.7.3 Employ authority or influence with RSA clients for the benefit of third parties, including the client's family or friends.
    - 2.7.4 Exploit the client's trust in the Contractor or its personnel for any purpose.
    - 2.7.5 Accept any commission, rebates, or any other form of remuneration when serving RSA clients, except payment for service provided from RSA.

**CONTRACTOR INVOICE FORM**

Billing Period (Month/Day/Year): From \_\_\_\_\_, \_\_\_\_\_ Through \_\_\_\_\_, \_\_\_\_\_  
 Invoice Number: \_\_\_\_\_

Contractor's name:	
Contractor's Phone Number:	Contractor's Fax Number:
Contract Number:	Contractor's FEI or SSN Number:
Contracted Service:	
RSA client's name:	

Service	RSA Authorization Number	Number of Units Billed	Contract Rate (\$)	Amount Billed
			\$	
			\$	
			\$	
<b>TOTAL AMOUNT BILLED</b>				

*"This invoice is a true and accurate account of the services listed on this statement for the time period specified; this invoice constitutes the full and complete charge for the services described above; that no further invoices for payment of these services will be made; these services have been provided without discrimination based on age, race, color, creed, gender, religion or national origin and that this statement is subject to federal and state audit review." The invoice shall be signed and dated by the person authorized to submit invoices for the Contractor.*

Name, title and phone number of the Contractor's designated person who prepared this form.

Name:

Title:

Phone Number:

Date:

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

ARIZONA DEPARTMENT OF ECONOMIC SECURITY  
Information Security Administration,  
1720 W. Madison St., Site 820Z  
Phoenix, AZ 85007  
Phone: (602) 771-2670 · Fax: (602) 364-0481

DATA-SHARING REQUEST/AGREEMENT

BETWEEN

REQUESTING ENTITY:

*Gila County dba Gila Employment & Special Training*  
(DES Division/Administration/Program/Office Name or External Organization Name)

AND

DATA MANAGER: ARIZONA DEPARTMENT OF ECONOMIC SECURITY

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(Division/Administration/Program/Office Name)

Effective Date: _____	Agreement No.: _____
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**SECTION I. REQUEST (Completed by Requesting Entity)**

*Use attachment if necessary*

1a. PURPOSE OF THIS REQUEST *(What information is being requested and why? How will it be used? Give details/specifics.)*

1b. INFORMATION TECHNOLOGY AND CONNECTIVITY

The requester enters all information required for successful communication between the requesting entity and the DES IT Staff.

Contact Name (1):	Phone: (    )    -
Contact Name (2):	Phone: (    )    -
Contact Address:	
Contact (1) E-Mail Address:	Contact (2) E-Mail Address:
Contact Fax No: (    )    -	

**SECTION I. (cont.) REQUEST (Completed by Requesting Entity)**

*Use attachment if necessary*

**2. CITE LAW, REGULATION, DIRECTIVE OR OTHER BASIS FOR THIS REQUEST**

Blank space for citing laws, regulations, directives, or other basis for the request.

**3. WILL OTHER ENTITIES INTERFACE WITH YOUR AGENCY?**

Yes  No      If Yes, identify entity and reason(s):

Blank space for identifying entities and reasons for interface.

**4. WILL INFORMATION BE DISCLOSED/SHARED WITH ANOTHER ENTITY?**

Yes  No      If Yes, identify entity and reason(s) for disclosure:

Blank space for identifying entities and reasons for disclosure.

**5. WILL DES DATA BE REPACKAGED/INCLUDED IN OTHER DATA BASES, FILES, TAPES, ETC.**

Yes  No      If Yes, identify entity and reason(s):

Blank space for identifying entities and reasons for data packaging.

**6. DESIRED OUTPUT (Printout, tape, terminal access/display, etc.)**

Blank space for describing desired output.

**7. DESCRIBE SAFEGUARDS IN PLACE TO GUARD AGAINST UNAUTHORIZED ACCESS/DISCLOSURE OF THE INFORMATION**

Blank space for describing safeguards.

PRINT NAME AND TITLE OF AUTHORIZED CONTACT	PHONE NO. (    ) - FAX        (    ) - E-MAIL	DATE	
MAILING ADDRESS/SITE CODE	CITY	STATE	ZIP CODE

<b>SECTION II. STIPULATIONS REGARDING THE USE OF INFORMATION</b>
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**STIPULATIONS APPLICABLE TO THE REQUESTING ENTITY:**

1. Disclosure of the data provided to the Requesting Entity is not permitted unless specifically authorized.
2. Repackaging or redistribution of data or screens, or creation of separate files will not be permitted unless specifically authorized.
3. The data shall be used only to assist in valid administrative needs as stated in Section I, item 1 of this Agreement.
4. All data shall be stored in a physically secure facility.
5. All data in electronic format shall be stored or processed so that unauthorized persons cannot retrieve the information by means of a computer, remote access, or other means.
6. Only authorized staff will be given access needed to accomplish the purpose(s) specified in Section I, item 1 of this Agreement.
7. All staff shall attend an authorized data security awareness training class, where they will be instructed on confidentiality, privacy laws and penalties imposed when compliance is breached. All staff with access to DES systems and/or applications must complete an annual recertification security awareness training class as scheduled by DES.
8. A Request for Terminal Access and Other Activity (J-125) shall be used to request specific access for each authorized staff member and must be signed by the staff supervisor or designee.
9. All authorized staff is required to sign a User Affirmation Statement (J-129), as a condition for using requested data. This affirmation statement must be resigned at three (3) year intervals as scheduled by DES.
10. Any personnel changes requiring change or removal of access as described in Section I, item 1 of this Agreement, shall be reported promptly to the respective data security analyst.
11. Federal and state audit and data security personnel may have access to offices and records of the requesting entity to monitor or verify compliance with this agreement.
12. This Data-Sharing Agreement will remain in effect for 10 years from the effective date unless otherwise stipulated in Section III or overridden by the Contract, a Memorandum Of Understanding or an InterAgency Agreement. If length is overridden by another document, please reference the document in Section III.

**STIPULATIONS APPLICABLE TO PROVIDER:**

1. DES will use the Requesting Entity employee identifying information solely for the purpose of establishing on-line access.
2. Only authorized DES employees will have access to requesting agency employee data.
3. In accordance with applicable federal, state, and/or local privacy regulations, DES will protect all information collected from the Requesting Entity.

**STIPULATIONS APPLICABLE TO HIPAA – HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT:**

1. All staff shall attend an authorized HIPAA awareness training class, where they will be instructed on confidentiality, privacy, information safeguards and penalties imposed when compliance is breached.
2. If applicable, there is a “Business Associate Contract” [45 CFR 164.502(e), 154.504(e), 164.532(d) & (e)] on file and will be attached to this data sharing agreement as an addendum.



**SECTION V. APPROVAL (Completed by the requesting entity and the data managing program)**

I attest to the correctness of the information provided in Section I and agree to the stipulations and costs listed in Section II and III. I agree to comply with all provisions of the DES Data Security Policy. Should any violations of the DES Data Security Policy occur, this Agreement may be terminated. I further understand that DES will periodically review the terms of the Agreement to ensure it conforms with DES Policies and Procedures. In the event changes in either federal or state law or regulations occur that conflict with the terms of the Agreement or render the terms of the Agreement void, impracticable, or otherwise impossible, this Agreement will terminate immediately. A new Agreement or an amendment to the existing Agreement will be initiated to provide for any changes, which cannot be accommodated within the provisions of the existing Agreement. The Requesting Entity shall hold harmless and indemnify the State of Arizona and its Department of Economic Security for any liability resulting from acts or omissions attributable to the Requesting Entity.

IN WITNESS HERETO, the PARTIES have executed this Agreement by signature of their duly authorized officials:

**For the Requesting Entity:**

Entity Name \_\_\_\_\_

Print Signatory Name \_\_\_\_\_

Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**For the Department of Economic Security:**

Entity Name \_\_\_\_\_

Print Signatory Name \_\_\_\_\_

Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**SECTION VI. APPROVAL (Completed by the Information Security Administration)**

This signed Agreement meets all requirements necessary to permit the controlled sharing of the DES data while simultaneously providing for the protection of the data. I certify that:

- THIS AGREEMENT CONFORMS to DES Information Security Policy.
- THIS AGREEMENT DOES NOT CONFORM to the DES Information Security Policy. Implementation of this Agreement cannot proceed until the following action is taken:

**Carl Carpenter**  
**DES Chief Information Security Officer**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(DATE)

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#### Equal Opportunity Employer/Program

• Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact Paul Chalker, DTS Information Risk Management, 602-771-2675; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.

Arizona Department of Economic Security  
Rehabilitation Services Administration  
Disability Related Employment Services

**CONTRACTOR'S QUALIFICATIONS PROFILE**

Contractor's Legal Business Name: Gila County dba Gila Employment + Special Training

Contractor's current employees and subcontractors who will provide Employment Services meet the qualifications requirements stated in Section 4.3 of the Scope of Work. Yes  No

Contractor is currently fully staffed with qualified employees, for delivery of Employment Services in each county proposed to serve. Yes  No

Briefly describe your experience in providing employment services to persons with disabilities:

Briefly describe a plan for being fully staffed with qualified employees, for delivery of the proposed service in each county you propose to serve:

Name of Authorized Individual: \_\_\_\_\_

Signature of Authorized Individual: \_\_\_\_\_

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

## **INDEPENDENT CONTRACTOR AGREEMENT**

**NOTE: THIS FORM APPLIES ONLY TO THE STATE OF ARIZONA AGENCIES, BOARDS, COMMISSIONS, AND UNIVERSITIES UTILIZING INDEPENDENT CONTRACTORS.**

**THIS FORM DOES NOT APPLY TO EMPLOYERS IN THE CONSTRUCTION INDUSTRY THAT USE A CONTRACTOR. A CERTIFICATE OF WORKERS' COMPENSATION INSURANCE OR A SOLE PROPRIETOR WAIVER MUST BE OBTAINED IN THOSE INSTANCES.**

This is a written agreement under the compulsory Workers' Compensation laws of the State of Arizona, **A.R.S. § 23-901** (et. seq.), and specifically **A.R.S. § 23-902** (C), (D), that an independent contractor relationship exists between the parties signed below. The parties agree that the "independent contractor" is independent of the "business" in the execution of the work and not subject to the rule or control of the "business" but is engaged only in the performance of a definite job or piece of work and is subordinate to the "business" only in effecting a result in accordance with that "business" design. The parties also agree that the "business" does not have the authority to supervise or control the actual work of the "independent contractor" or the "independent contractor's" employees. Furthermore, it is understood and agreed that the "independent contractor" or the "independent contractor's" employees are not entitled to workers' compensation benefits from the "business."

The written agreement shall be null and void and create no presumption of an independent contractor relationship if the consent of either party is obtained through misrepresentation, false statements, fraud or intimidation, coercion or duress.

### **WE THE UNDERSIGNED AGREE THAT THE BUSINESS:**

- Does not require the independent contractor to perform work exclusively for the business. This paragraph shall not be construed as conclusive evidence that an individual who performs services primarily or exclusively for another person is an employee of that person.
- Does not provide the independent contractor with any business registrations or licenses required to perform the specific services set forth in the contract.
- Does not pay the independent contractor a salary or hourly rate instead of an amount fixed by contract.
- Will not terminate the independent contractor before the expiration of the contract period, unless the independent contractor breaches the contract or violates the laws of this state.
- Does not provide tools to the independent contractor.
- Does not dictate the time of performance.
- Pays the independent contractor in the name appearing on the written agreement.
- Will not combine business operations with the person performing the services rather than maintaining these operations separately.

## **INDEPENDENT CONTRACTOR AGREEMENT**

<b>NAME OF INDEPENDENT CONTRACTOR:</b> _____		
<b>ADDRESS / P.O. BOX:</b> _____		
<b>CITY:</b> _____	<b>STATE:</b> _____	<b>ZIP:</b> _____
<b>SIGNATURE OF INDEPENDENT CONTRACTOR:</b> _____		<b>DATE:</b> _____

<b>STATE OF ARIZONA</b>	
<b>AGENCY:</b> _____	<b>AGENCY#:</b> _____
<b>ADDRESS:</b> _____	
<b>CITY:</b> _____	<b>STATE:</b> _____ <b>ZIP:</b> _____
<b>SIGNATURE OF AGENCY CONTRACT ADMINISTRATOR:</b> _____	
<b>DATE:</b> _____	
<b>CONTRACT IDENTIFICATION:</b> _____	

**BOTH SIGNATURES MUST BE SIGNED AND THE COMPLETED FORM SUBMITTED TO:**

**ARIZONA DEPARTMENT OF ADMINISTRATION  
RISK MANAGEMENT DIVISION - INSURANCE UNIT  
100 NORTH 15<sup>th</sup> AVENUE, SUITE #301  
PHOENIX, AZ 85007**

An authorized Risk Management Representative will sign your completed form and return it to the agency to be maintained in their records.

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<b>Signature of Risk Management Authorized Signer</b>	<b>Date</b>
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## REQUEST FOR SEARCH OF CENTRAL REGISTRY FOR BACKGROUND CHECK

This document and any files transmitted with it are confidential and intended solely for the use of the individual or entity to which they are addressed. If you have received this information in error, please notify the sender and destroy the information. The information contained in the Arizona Department of Child Safety (ADCS), CHILDS Central Registry and any attached files shall be used as a factor to determine qualifications for individuals applying for contracts with this state, including employees of the prospective contractor, contractors, and subcontractors for positions that provide direct services to children or vulnerable adults. The information contained in the Central Registry for Background Check and any attached files is confidential and shall not be further disseminated or shared.

**PLEASE FILL OUT THE INFORMATION BELOW.** All fields must be completed, accurately and legibly, type or print only.

**Offeror, Contractor, or Subcontractor Name**

Solicitation Number: Disability Related Employment Services		Contract Number: TBD
Tracking Number ( <i>You must provide your unique tracking number. This number will be used to identify and track this document and the individuals linked to it.</i> ):		Check One: <input type="checkbox"/> New Contract <input type="checkbox"/> Contract Extension <input type="checkbox"/> New employee hire
Phone Number	Email Address	
Mailing Address		
Name of Person Authorized to Submit Request Attesting to the Presence of a Signed Direct Service form for each request		
Requester's Signature		Date of Request
Department / Division	Department / Division Contact Person	

**SUBMIT YOUR COMPLETED CENTRAL REGISTRY REQUEST THROUGH ONE OF THE FOLLOWING METHODS:**

**Mail to:** Department of Child Safety  
Office of Licensing & Regulation  
ATT: Central Registry  
PO Box 6123, Site Code 076A  
Phoenix, AZ 85005-6123

**Fax to:** Central Registry Request at 602-265-3993

**Email (secured) to:** [DCYFCentralRegistryCheck@azdes.gov](mailto:DCYFCentralRegistryCheck@azdes.gov)

**RESULTS of this check will be:**

1. EMAILED to the address above indicating that one or more individuals on the request was (were) unable to be processed with the information provided; or
2. EMAILED to the address above if all names are cleared; or
3. EMAILED to the address above with information on individuals who are found to have a substantiated finding of child abuse or neglect on the Central Registry; and
4. MAILED to the individual who is found to have a substantiated finding on the Central Registry that disqualifies him/her from providing direct services to children or vulnerable adult clients of DCS.

**Internal Use Only:**

For Solicitations Only: DCS Designated Staff (Office of Procurement):

For Contracts: Notify DCS Designated Staff (Program): [RSAContractsUnit@azdes.gov](mailto:RSAContractsUnit@azdes.gov)

**REQUEST FOR SEARCH OF CENTRAL REGISTRY FOR BACKGROUND CHECK**  
*(All fields must be completed, accurately and legibly, print or type only)*

INDIVIDUAL'S INFORMATION	
NAME	ALIAS (Previously used name(s))
SOC. SEC. NO.	DATE OF BIRTH
ADDRESS (No., Street, City, State, ZIP)	
DCS – INTERNAL USE ONLY (Search results)	
Reports: <input type="checkbox"/> Yes	Number: <i>[See attached document(s)]</i> <input type="checkbox"/> No
Date of Search:	
NAME OF PERSON COMPLETING SEARCH	SIGNATURE

INDIVIDUAL'S INFORMATION	
NAME	ALIAS (Previously used name(s))
SOC. SEC. NO.	DATE OF BIRTH
ADDRESS (No., Street, City, State, ZIP)	
DCS – INTERNAL USE ONLY (Search results)	
Reports: <input type="checkbox"/> Yes	Number: <i>[See attached document(s)]</i> <input type="checkbox"/> No
Date of Search:	
NAME OF PERSON COMPLETING SEARCH	SIGNATURE

INDIVIDUAL'S INFORMATION	
NAME	ALIAS (Previously used name(s))
SOC. SEC. NO.	DATE OF BIRTH
ADDRESS (No., Street, City, State, ZIP)	
DCS – INTERNAL USE ONLY (Search results)	
Reports: <input type="checkbox"/> Yes	Number: <i>[See attached document(s)]</i> <input type="checkbox"/> No
Date of Search:	
NAME OF PERSON COMPLETING SEARCH	SIGNATURE

INDIVIDUAL'S INFORMATION	
NAME	ALIAS (Previously used name(s))
SOC. SEC. NO.	DATE OF BIRTH
ADDRESS (No., Street, City, State, ZIP)	
DCS – INTERNAL USE ONLY (Search results)	
Reports: <input type="checkbox"/> Yes	Number: <i>[See attached document(s)]</i> <input type="checkbox"/> No
Date of Search:	
NAME OF PERSON COMPLETING SEARCH	SIGNATURE

**REQUEST FOR SEARCH OF CENTRAL REGISTRY FOR BACKGROUND CHECK**  
*(All fields must be completed, accurately and legibly, print or type only)*

INDIVIDUAL'S INFORMATION		
NAME	ALIAS (Previously used name(s))	
SOC. SEC. NO.	DATE OF BIRTH	
ADDRESS (No., Street, City, State, ZIP)		
DCS – INTERNAL USE ONLY (Search results)		
Reports: <input type="checkbox"/> Yes	Number: [See attached document(s)] <input type="checkbox"/> No	Date of Search:
NAME OF PERSON COMPLETING SEARCH	SIGNATURE	

INDIVIDUAL'S INFORMATION		
NAME	ALIAS (Previously used name(s))	
SOC. SEC. NO.	DATE OF BIRTH	
ADDRESS (No., Street, City, State, ZIP)		
DCS – INTERNAL USE ONLY (Search results)		
Reports: <input type="checkbox"/> Yes	Number: [See attached document(s)] <input type="checkbox"/> No	Date of Search:
NAME OF PERSON COMPLETING SEARCH	SIGNATURE	

INDIVIDUAL'S INFORMATION		
NAME	ALIAS (Previously used name(s))	
SOC. SEC. NO.	DATE OF BIRTH	
ADDRESS (No., Street, City, State, ZIP)		
DCS – INTERNAL USE ONLY (Search results)		
Reports: <input type="checkbox"/> Yes	Number: [See attached document(s)] <input type="checkbox"/> No	Date of Search:
NAME OF PERSON COMPLETING SEARCH	SIGNATURE	

INDIVIDUAL'S INFORMATION		
NAME	ALIAS (Previously used name(s))	
SOC. SEC. NO.	DATE OF BIRTH	
ADDRESS (No., Street, City, State, ZIP)		
DCS – INTERNAL USE ONLY (Search results)		
Reports: <input type="checkbox"/> Yes	Number: [See attached document(s)] <input type="checkbox"/> No	Date of Search:
NAME OF PERSON COMPLETING SEARCH	SIGNATURE	

**REQUEST FOR SEARCH OF CENTRAL REGISTRY FOR BACKGROUND CHECK**  
*(All fields must be completed, accurately and legibly, print or type only)*

INDIVIDUAL'S INFORMATION	
NAME	ALIAS (Previously used name(s))
SOC. SEC. NO.	DATE OF BIRTH
ADDRESS (No., Street, City, State, ZIP)	
DCS – INTERNAL USE ONLY (Search results)	
Reports: <input type="checkbox"/> Yes	Number: [See attached document(s)] <input type="checkbox"/> No
Date of Search:	
NAME OF PERSON COMPLETING SEARCH	SIGNATURE

INDIVIDUAL'S INFORMATION	
NAME	ALIAS (Previously used name(s))
SOC. SEC. NO.	DATE OF BIRTH
ADDRESS (No., Street, City, State, ZIP)	
DCS – INTERNAL USE ONLY (Search results)	
Reports: <input type="checkbox"/> Yes	Number: [See attached document(s)] <input type="checkbox"/> No
Date of Search:	
NAME OF PERSON COMPLETING SEARCH	SIGNATURE

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**REQUEST FOR SEARCH OF CENTRAL REGISTRY FOR BACKGROUND CHECK**  
*(All fields must be completed, accurately and legibly, print or type only)*

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NAME	ALIAS (Previously used name(s))
SOC. SEC. NO.	DATE OF BIRTH
ADDRESS (No., Street, City, State, ZIP)	
DCS – INTERNAL USE ONLY (Search results)	
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DCS – INTERNAL USE ONLY (Search results)	
Reports: <input type="checkbox"/> Yes	Number: [See attached document(s)] <input type="checkbox"/> No Date of Search:
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# REQUEST FOR SEARCH OF CENTRAL REGISTRY FOR BACKGROUND CHECK

(All fields must be completed, accurately and legibly, print or type only)

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## DISQUALIFICATION ACTS

A person is disqualified from providing services to DCS clients in a direct service position if he/she is identified as the subject of the substantiated report for any of the following.

24 Child death due to alleged abuse or neglect, or suspicious death
25 Injuries requiring emergency medical treatment
27 Child age 24 months is shaken (shaken baby syndrome)
33 Untreated life threatening condition, Infant Doe, Non-organic FTT
37 Imminent harm to child under the age of six (6) due to lack of supervision by parent/caretaker
38 Neglect results in injury/illness requiring emergency medical treatment
39 Imminent harm to child due to health or safety hazards in living environment/exposure to the elements
40 Child diagnosed as suicidal by mental health professions, parent refused to allow treatment
41 Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past seven days
42 Child reporting vaginal or anal penetration or oral sexual contact within past 72 hours and has not been examined
43 Abandoned, no parent willing to provide immediate care for a child and child is with a caregiver unable or unwilling to provide care now
45 Injuries may require medical treatment
46 P3 Injury to child under age six years
50 Living environment presents health or safety hazards to a child under the age of six
51 Sexual conduct/physical injury between children due to inadequate supervision
54 Sexual behavior within the past 8-14 days
55 Child diagnosed by mental health professional with behavior consistent with emotional abuse
56 Abandoned, no parent willing to care for a child, child with caretaker unable or unwilling to care for child less than one week
66 Significant developmental delays due to neglect
69 Attempted sexual behavior or sexual behavior, 14 days to three years r last occur unknown
72 Parent, guardian or custodian suggests or entices child to engage in sexual behavior, no touching
76 Use of child by parent, guardian or custodian for material gain
82 Parent, guardian or custodian sexually abused a child in past, now in home with a child
83 Attempted sexual behavior or sexual behavioral when last occurred more than three years
101 Death of a child due to neglect
111 Death of a child due to physical abuse or suspicious death
201 Physical abuse high risk
202 Physical abuse moderate risk
301 Neglect, high risk
302 Neglect, moderate risk
401 Sexual abuse, high risk
402 Sexual abuse, moderate risk
403 Sexual Abuse, low risk
404 Sexual Abuse, response 4
501 Emotion Abuse, high risk
502 Emotional abuse, moderate risk

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DCS services is available upon request. • Disponible en español en línea o en la oficina local.



# State of Arizona Substitute W-9 & Vendor Authorization Form

**Purpose:** Establish or update a vendor account with the State of Arizona. This form meets the Federal requirements to request a taxpayer identification number (TIN), request certain certifications and claims for exemption, as well as the State of Arizona requirements for vendor establishment.

**Instructions:** Complete form if

1. You are a U.S. person (including a resident alien);
2. You are a vendor that provides goods or services to an Arizona state agency; **AND**
3. You will receive payment from the State of Arizona.

**Return completed form to the state agency with whom you do business, for review and authorization.**

See instructions below or refer to the IRS instructions at [www.irs.gov](http://www.irs.gov) for details on completing this form.

**Type of Request (Must select at least ONE)**

New Request

New Location (Additional Mail Code)

Change (Select the type(s) of change from the following:

- Tax ID  Legal Name  Entity Type  Minority Business Indicator  
 Main Address  Remittance Address  Contact Information

**Taxpayer Identification Number (TIN) (Provide ONE Only)**

Social Security Number (SSN) [ ] - [ ] - [ ]

OR Federal Employer Identification Number (FEIN) 86 - 6000444

**Entity Name Must Provide Legal Name (\*Must match SSN or FEIN given. If Individual or Sole Proprietorship enter First, Middle, Last Name.)**

Legal Name\* **Gila County Treasurer**

**Entity Type Must Select One of the Following (Coding (X#) is for Internal Purposes Only)**

- Individual/Sole Proprietor or Sole Proprietor organized as LLC, PLLC (6I)  State of Arizona employee (1E) STATE HRIS EIN [ ]
- Corporation NOT providing health care, medical or legal services (5A)  LLC, PLLC organized as corporation NOT providing health care, medical or legal services (5A)
- Corporation providing health care, medical or legal services (5M)  LLC, PLLC organized as corporation providing health care, medical or legal services (5M)
- Partnership, LLP or Partnership organized as LLC or PLLC (5C)  A state, a possession of the US, or any of their political subdivisions or instrumentalities (4G)
- An international organization or any of its agencies/instrumentalities (5U)  Other: Tax Reportable Entity (5P) Description [ ]
- The US or any of its political subdivisions or instrumentalities (2G)  Other: Tax Exempt Entity (5H)

**Minority Business Indicator Must select one of the following (Coding (X#) is for internal purposes only)**

- Small Business (01)  Small, Woman Owned Business- Hispanic (31)  Minority Owned Business- African American (04)
- Small Business- African American (23)  Small, Woman Owned Business- Native American (33)  Minority Owned Business- Asian (32)
- Small Business- Asian (24)  Small, Woman Owned Business- Other Minority (11)  Minority Owned Business- Hispanic (74)
- Small Business - Hispanic (25)  Woman Owned Business (03)  Minority Owned Business- Native American (15)
- Small Business- Native American (27)  Woman Owned Business- African American (17)  Minority Owned Business- Other Minority (02)
- Small Business- Other Minority (05)  Woman Owned Business- Asian (18)  Non-Profit, IRC §501(c) (88)
- Small, Woman Owned Business (06)  Woman Owned Business- Hispanic (19)  Non-Small, Non-Minority or Non-Woman Owned Business (00)
- Small, Woman Owned Business- African American (29)  Woman Owned Business- Native American (21)
- Small, Woman Owned Business- Asian (30)  Woman Owned Business- Other Minority (08)  Individual, Non-Business (00)

**Main Address** Where tax information and general correspondence is to be mailed

**Remittance Address** Where payment is to be mailed  Same as Main

DBA/Branch/Location **Gila County Treasurer**

Address **1400 East Ash Street**

City **Globe** State **AZ-ARIZONA** Zip code **85502**

DBA/Branch/Location [ ]

Address [ ]

City [ ] State [ ] Zip code [ ]

**Vendor Contact Information**

Name **Helene Lopez** Title **GEST Program Manager**

Phone # **928 425 7631** Ext. **8864** Fax **928-425-9466** Email **hlopez@gilacountyaz.gov**

**Certification**  Exempt from backup withholding

Under Penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) AND
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding AND
3. I am a U.S. person (including U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.

**The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.**

Signature **Debra Saenz** Title **Gila County Treasurer** Date **01-14-2014**

**STATE OF ARIZONA AGENCY USE ONLY - AGENCY AUTHORIZATION**

**VENDOR: DO NOT WRITE BELOW THIS LINE**

State HRIS EIN [ ] Print Name [ ] Signature [ ]

AGY [ ] Title [ ] Phone # [ ] Email [ ] Date [ ]

**STATE OF ARIZONA GAO USE ONLY**

**VENDOR & STATE AGENCY: DO NOT WRITE BELOW THIS LINE**

IRS TIN Matching  Corporation Commission Vendor Number [ ] Processed by [ ] Date Processed [ ]

HRIS  GAO-03  Other