



## REQUEST FOR APPLICATION FOR ARIZONA LONG TERM CARE SERVICES



To start the application process, complete this form and return using one of the methods found on page 4 of this Request for an Application.

### Customer Information

Customer's Name (Last, First, Middle)		Customer's Date of Birth	
Customer's Social Security Number		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married (including separated if not legally divorced) <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed            Date of spouse's death: _____			
Spouse's Name (Last, First, Middle)		Spouse's Date of Birth	
Spouse's Social Security Number (optional if not applying)			
Customer's Home Address			
City		State	Zip Code
Customer's Mailing Address (if different from home address)			
City		State	Zip Code
Phone Number		E-Mail Address	

### Authorized Representative and Legal Guardian/Conservator Information

Name of the Customer's Authorized Representative		Relationship to Customer	
Name of the Customer's Legal Guardian/Conservator		Relationship to Customer	
Authorized Representative's Mailing Address			
City		State	Zip Code
Phone Number		E-Mail Address	
Legal Guardian's/Conservator's Mailing Address			
City		State	Zip Code
Phone Number		E-Mail Address	

### Customer's Current Living Arrangement

Where is the customer currently residing? <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> At Home <input type="checkbox"/> Other: _____		Expected Date of Discharge
Name of the Hospital, Assisted Living or Nursing Facility		Phone Number
Hospital, Assisted Living, or Nursing Facility Address		
City	State	Zip Code

### Accommodations for Printed Letters

Does the customer, authorized representative, or legal guardian have a visual impairment that requires an alternative format for printed letters?  
 No     Yes    If yes, who needs the accommodation:

If yes, what kind of alternative format do you need? Please choose one option:

Readable PDF sent by secure email  
 Large print: larger print letters sent by U.S. mail will be provided Arial 24 point font.  
 Other:

### Additional Questions

Does the customer need help paying for medical bills from the last three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what months? _____
Is the customer receiving services from the DES Division of Developmental Disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date services began: _____
<b>Prior to the age of 18</b> was the customer <b>diagnosed</b> with any of the following medical conditions? Check all that apply.	<input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Intellectual/Cognitive Disability <input type="checkbox"/> Seizure Disorder
<b>If the customer is under age of 6</b> , has the customer been <b>diagnosed</b> with Developmental Delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the customer a trustor, trustee, or beneficiary of any type of trust?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the customer sold, traded, transferred, or given away any assets within the last five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Interview Information:** An interview is required to complete the ALTCS application process. The customer is not required to attend the financial interview if the legal guardian/conservator or authorized representative completes the interview for the applicant.

What are the best days and times for you to complete the interview?

Monday      Time: \_\_\_\_\_  
 Tuesday      Time: \_\_\_\_\_  
 Wednesday    Time: \_\_\_\_\_  
 Thursday      Time: \_\_\_\_\_  
 Friday        Time: \_\_\_\_\_

Does the person completing the interview need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what language? _____
<p>In case a home visit is needed, please provide the following information:  Address or location for home visit (if the home is in a rural area, please attach a map)</p> <p>_____</p> <p>Major crossroads _____</p>	

### HOW WE WILL USE YOUR INFORMATION

The following information describes how your personal information will be used by Health-e-Arizona Plus, AHCCCS, DES, and their contractors.

- We will use your information, including Social Security number, to computer match with financial institutions, state, local, and federal agencies and our other programs to verify information. Income and verification systems such as the Social Security Administration, State Unemployment Insurance and State Wage may be used. This information may affect eligibility and benefit level.
- Applying and providing information is voluntary, but some information is required to make a determination. For example, you must provide or apply for a Social Security number for every applicant. (Immigrants who are not legally able to obtain a Social Security number are not required to provide one.) Therefore, if personal information is not provided, you may not be eligible for benefits.

Name of Person Completing Form	Phone Number
--------------------------------	--------------

The person completing this form is the:

- Customer
- Spouse of the customer
- Parent of the customer (if the customer is a minor)

If one of the boxes above is checked, the person completing this form must:

- check the box below; and
- sign this form below.

If one of the boxes above is **NOT** checked, the person completing this form may:

- complete an Authorized Representative form found at: <https://www.azahcccs.gov/Members/GetCovered/apply.html>;
- attach the completed Authorized Representative form with this request for an application;
- check the box below; and
- sign this form below.

A request for an application may be returned without the completed authorized representative form, checking the box below and signing below, but may cause the application process to take more time.

<input type="checkbox"/> I agree to allow you to check information sources and use it for this application.	
Signature	Date

AHCCCS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Return the completed request for an application using one of the methods below:**

**Mail:**

Centralized Support Unit  
801 East Jefferson MD 3900  
Phoenix, Arizona 85034

**Fax:**

1-888-507-3313

**Take to a local ALTCS office:**

**CASA GRANDE**

201 E Cottonwood Lane  
Suite 2  
Casa Grande, Arizona 85122  
Phone: 520-421-1500  
Toll Free: 1-855-277-0260

**PHOENIX**

801 East Jefferson  
Phoenix, Arizona 85034  
Phone: 602-417-6600

**CHINLE**

Tseyi Shopping Center, Hwy 191  
Chinle, Arizona, 86503  
Phone: 928-674-5439  
Toll Free: 1-888-800-3804

**PRESCOTT**

3262 Bob Drive  
Suite 11  
Prescott Valley, Arizona 86314  
Phone: 928-778-3968  
Toll Free: 1-888-778-5600

**COTTONWOOD**

1500 E. Cherry Street  
Suite I  
Cottonwood, Arizona 86326  
Phone: 928-634-8101  
Toll Free: 1-855-873-0393

**TUCSON**

1010 North Finance Center Drive  
Suite 201  
Tucson, Arizona 85710  
Phone: 520-205-8600  
Toll Free: 1-800-824-2656

**FLAGSTAFF**

2717 North Fourth Street,  
Suite 130  
Flagstaff, Arizona 86004  
Phone: 928-527-4104  
Toll Free: 1-800-540-5042

**YUMA**

3850 West 16<sup>th</sup> Street  
Suite A  
Yuma, Arizona 85364  
Phone: 928-782-0776  
Toll Free: 1-855-419-6527

**KINGMAN**

519 East Beale Street  
Suite 130  
Kingman, Arizona 86401  
Phone: 928-753-2828  
Toll Free: 1-888-300-8348