ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

# Request For Application For Arizona Long Term Care System (ALTCS)

Customer Address:

To start the application process, you can call us at **888-621-6880 (toll-free)** or register an application online at Health-e-Arizona Plus. You may also complete this form and return it using one of the methods found on page 4 of this Request for Application. Missing or incomplete information may cause a delay in the processing of your application. Bolded questions are required to be answered in order for us to register the application.

## Customer Information

| | |
|---|---|
| **Customer's Legal Name** (First, Middle Initial, Last, Suffix): | **Customer's Date of Birth**: |
| Customer's Social Security Number: | ☐ Male ☐ Female |
| Marital Status: ☐ Never Married ☐ Married (including separated if not legally divorced) ☐ Divorced ☐ Widowed Date of spouse's death: | |
| Spouse's Legal Name (First, Middle Initial, Last, Suffix): | Spouse's Date of Birth: |
| Spouse's Social Security Number (optional if not applying): | |
| Customer's Home Address: | Customer's Mailing Address (if different from home address): |
| Phone Number: | E-mail Address: |

## Authorized Representative/Spouse and Legal Guardian/Conservator Information

| | |
|---|---|
| Name of the Customer's Authorized Representative: | Relationship to Customer: |
| Representative Date of Birth (optional): | Name of the Representative Organization (when applicable): |
| 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? ☐ Hospital ☐ Nursing Facility ☐ At Home ☐ Other: | Date Admitted: | 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 expenses from the last three months?<br>Is the customer pregnant or had a pregnancy end in the last 5 months? | ☐ Yes ☐ No If yes, what months?<br>☐ Yes ☐ No |
| Is the customer receiving services from the DES Division of Developmental Disabilities? | ☐ Yes ☐ No<br>If yes, date services began: |
| **Prior to the age of 18** was the customer **diagnosed** with any of the following medical conditions? Check all that apply. | ☐ Autism<br>☐ Cerebral Palsy<br>☐ Intellectual/Cognitive Disability<br>☐ Down syndrome<br>☐ Seizure Disorder |
| **If the customer is under the age of 6**, has the customer been **diagnosed** with Developmental Delay? | ☐ Yes ☐ No |
| Is the customer a trustor, trustee, or beneficiary of any type of trust? | ☐ Yes ☐ No |
| Has the customer sold, traded, transferred, or | ☐ Yes ☐ No |

| given away any assets within the last five years? | |
|---|---|

**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 customer.

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? ☐ Yes ☐ No | If yes, what language? |
|---|---|

## 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 on the next page; and
- sign this form on the next page.

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 on the next page; and
- sign this form on the next page.

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.

☐ 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.

To submit a Request for Application by phone, or for help contact:

**Arizona Long Term Care System (ALTCS)**

Call (toll-free): 888-621-6880

A completed Request for Application may also be returned by:

- **Online:** Health-e-Arizona Plus
- **Fax (toll-free):** 888-507-3313
- **E-mail:** altcsregistration@azahcccs.gov
- **Mail:** AHCCCS
  P.O. Box 6050
  MD 15023 ALTCS
  Phoenix AZ 85002-5520

**A completed Request for Application may also be taken to a local ALTCS office:**

| | |
|---|---|
| **CHINLE**<br>Tseyi Shopping Center Hwy 191<br>Chinle AZ 86503 | **PHOENIX**<br>150 N. 18th Ave 2nd Floor<br>Phoenix AZ 85007 |
| **FLAGSTAFF**<br>1701 N Fourth St<br>Flagstaff AZ 86004 | **TUCSON**<br>4760 S. Park Ave<br>Tucson AZ 85714 |
| **KINGMAN**<br>2400 Airway Ave<br>Kingman AZ 86409 | **YUMA**<br>1800 E Palo Verde St<br>Yuma AZ 85365 |

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

# Authorization To Disclose Protected Health Information To AHCCCS

Attention ALTCS Customer:

Please complete the “Authorization to Disclose Protected Health Information to AHCCCS” form. A signature on the form is required by one of the following people:

- Customer;
- Customer’s parent if the customer is under the age of 18; or
- Customer’s Legal Guardian or Legal Representative. Copy of court documents must be provided.

Return this completed form using one of the return options below. For any questions, call (602) 417-6600 or toll-free (888) 621-6880. Please note, returning this form quickly will allow us to assist in getting medical documentation for your application.

Return Options:
**Fax (toll-free):** 888-507-3313
**E-mail:** altcsregistration@azahcccs.gov
**Mail:** AHCCCS
P.O. Box 6050
MD 15023 ALTCS
Phoenix AZ 85002-5520

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

# Authorization To Disclose Protected Health Information To AHCCCS

| | |
|---|---|
| Customer Name: | Date of Birth: |
| AHCCCS ID Number or PID: | Date of Request: |
| Customer Address: | Social Security Number (SSN):<br><br>(SSN is optional but may help the provider locate records) |

## For use by AHCCCS customers/applicants who want a doctor or other entity to give AHCCCS their protected health information.

I give my permission for any health care provider to disclose any of my protected health information to AHCCCS, for the purpose of determining my eligibility for any of the publicly-funded programs administered by AHCCCS. I give AHCCCS permission to share this information with the Arizona Department of Economic Security, Disability Determination Services Administration, if necessary, to determine my disability status.

| In addition, by checking these boxes, I specifically authorize the disclosure of the following types of medical records: | |
|---|---|
| Medical Records | |
| ☐ | HIV/AIDS and communicable disease related information and/or records |
| ☐ | Mental health information and/or records |
| ☐ | Genetic testing information and/or records |
| ☐ | Alcohol and drugs screening information and/or records |
| School Records | |
| ☐ | Educational and evaluation records |

By signing this Authorization, I understand that:

- AHCCCS is required by state and federal law to keep confidential the information described above and may only use or disclose that information with my approval, for purposes directly related to the administration of the AHCCCS program, or as otherwise permitted or required by law.

- I understand that if I revoke this authorization or refuse to sign, AHCCCS may not be able to determine my current or future eligibility for the publicly funded medical assistance programs administered by AHCCCS. As a result, my application for assistance may be denied or the assistance may be discontinued.

- I may **revoke** this authorization at any time, in writing, by phone, or fax by completing an AHCCCS “Revocation of Authorization” form, and sending it to:

  AHCCCS - Office of the General Counsel

Attention: Privacy Officer
PO Box 6050
MD 15013
Phoenix AZ 85002-5520
Phone 602-417-4455
Fax 1-602-253-9115

Once AHCCCS receives the revocation, this authorization will be revoked, except to the extent that AHCCCS has already taken action in reliance upon this authorization.

I may revoke this authorization upon a certain date, event, or both by completing the selection below. If I do not specify a date or event, this authorization will remain active for 1 year from the date of signature unless AHCCCS is notified that this authorization is revoked.

| This authorization will expire on: | | |
|---|---|---|
| ☐ | Insert specific date: | |
| ☐ | Insert specific event: | |

**The customer's signature is required to get medical records. If the customer is under the age of 18, the signature of the customer's parent is needed. If the customer has a legal guardian or legal representative, the signature of the legal guardian or legal representative is needed.**

| Signature | Date: |
|---|---|
| Printed name of person signing form: | Relationship to customer: |
| Printed name of witness (only needed if customer signed with mark): | Signature of witness: |

AHCCCS will not pay for medical records per Arizona Administrative Code R9-22-512.E.

| **Return Information to**:<br><br>AHCCCS<br>P.O. Box 6050 MD 15023<br>Phoenix AZ 85002-5520<br>Fax: 888-507-3313 | AHCCCS Worker Name:<br>E-mail:<br>Phone Number: |
|---|---|