



## 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)**. You may also complete this form and return it using one of the methods found on page 4 of this Request for 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		Customer's Mailing Address ( <u>if different</u> 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	
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: _____	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

<p>Does the customer, authorized representative, or legal guardian have a visual impairment that requires an alternative format for printed letters?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, who needs the accommodation: <p>If yes, what kind of alternative format do you need? Please choose one option:</p> <input type="checkbox"/> Readable PDF sent by secure email <input type="checkbox"/> Large print: larger print letters sent by U.S. mail will be provided Arial 24 point font. <input type="checkbox"/> Other: _____
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### Additional Questions

Does the customer need help paying for medical expenses from the last three months? Is the customer pregnant or had a pregnancy end in the last 5 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what months? <input type="checkbox"/> Yes <input type="checkbox"/> No
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?	
<input type="checkbox"/> Monday	Time: _____
<input type="checkbox"/> Tuesday	Time: _____
<input type="checkbox"/> Wednesday	Time: _____
<input type="checkbox"/> Thursday	Time: _____
<input type="checkbox"/> Friday	Time: _____
Does the person completing the interview need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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 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:

- **Fax (toll-free):** 888-507-3313
- **Email:** [altcsregistration@azahcccs.gov](mailto:altcsregistration@azahcccs.gov)
- **Mail:** ALTCS  
801 East Jefferson Street  
MD 3900  
Phoenix, AZ 85034

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

<b>CASA GRANDE</b> 201 East Cottonwood Lane, Suite 2 Casa Grande, Arizona 85122	<b>PHOENIX</b> 801 East Jefferson Street Phoenix, Arizona 85034
<b>CHINLE</b> Tseyi Shopping Center, Hwy 191 Chinle, Arizona, 86503	<b>PRESCOTT</b> 3262 Bob Drive, Suite 11 Prescott Valley, Arizona 86314
<b>COTTONWOOD</b> 1500 East Cherry Street, Suite I Cottonwood, Arizona 86326	<b>TUCSON</b> 7202 E Rosewood Street, Suite 125 Tucson, Arizona 85710
<b>FLAGSTAFF</b> 2717 North Fourth Street, Suite 130 Flagstaff, Arizona 86004	<b>YUMA</b> 1800 E Palo Verde St Yuma, Arizona 85365
<b>KINGMAN</b> 2400 Airway Avenue Kingman, Arizona 86409	



## 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

**Email:** [altcsregistration@azahcccs.gov](mailto:altcsregistration@azahcccs.gov)

**Mail:** AHCCCS

801 E. Jefferson St.

MD 3900

Phoenix, AZ 85034



## Authorization To Disclose Protected Health Information To AHCCCS

<b>Return Information to:</b>  AHCCCS 801 E. Jefferson St. MD 3900 Phoenix, AZ 85034 Fax: 888-507-3313	AHCCCS Worker Name:
	Email:
	Phone Number:

Customer Name:	Date of Birth:
AHCCCS ID Number or PID:	Date of Request:
Customer Address:	Social Security Number (SSN):  (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:	
<input type="checkbox"/>	HIV/AIDS and communicable disease related information and/or records
<input type="checkbox"/>	Mental health information and/or records
<input type="checkbox"/>	Genetic testing information and/or records

**If the information to be disclosed comes from a school, please fill out this box:**

<input type="checkbox"/> I specifically authorize the holder of my information to disclose all of my educational and evaluation records in its possession to AHCCCS.
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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 also understand that if I refuse to sign or revoke this authorization, 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, in writing, at any time, by completing an AHCCCS “Revocation of Authorization” form, and sending it to:  
 Arizona Health Care Cost Containment System  
 Office of Legal Assistance  
 Attention: Privacy Officer  
 801 E. Jefferson, MD 6200  
 Phoenix, AZ 85034  
 Phone 602-417-4232  
 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.

Please choose one of the following:

This authorization will expire on:		
<input type="checkbox"/>	Insert specific date:	
<input type="checkbox"/>	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: