

AHCCCS HRSN Delegation Form

Screening and Referral Processes

Participating Organization Name
Participating Organization Tax ID
Name of Accountable Care Organization/ Clinically Integrated Network

This form is only applicable to Targeted Investments Program (TI 2.0) participants who use a system sponsored by an Accountable Care Organizations (ACOs) or Clinically Integrated Networks (CINs) to facilitate and document any Health-Related Social Needs (HRSN) screening and/or HRSN referrals for AHCCCS members for the remainder of the program.

Participants are responsible for accurately attesting and submitting documentation to satisfy all TI 2.0 milestones as of the moment attestation is submitted. In the event a post-pay audit finds the participant did not correctly attest or submit sufficient documentation for a paid milestone, any payment associated with the milestone may be recouped from the participating provider organization.

The form supports attestation for TI 2.0 Year 3 milestones M3 and M4 by confirming the ACO/CIN's commitment to assisting the provider organization with facilitating and/or documenting HRSN screening and referrals for each AHCCCS ACC and ACC/RBHA health plan and age cohort from 9/30/2025 to present.

Participants must email targetedinvestments@azahcccs.gov if any changes occur before 9/30/2027.

Instructions:

1. Participating Provider creates a form for each ACO/CIN used for HRSN screening and/or referrals.
2. Select all applicable checkboxes.
3. Send the completed form(s) to the ACO/CIN representative for signature.
4. Upload the signed HRSN Delegation Form to the AHCCCS Online TI 2.0 Program Year 3 Application Portal.

AHCCCS COMPLETE CARE (ACC) HEALTH PLANS

Add a check mark next to health plans that facilitate HRSN referrals for your organization.
 Add a check mark next to the age cohorts that receive these referrals for each health plan.
 If there have been, or are expected to be, changes in the ACO/CIN completing these activities since 9/30/2025, indicate the begin and end dates.

Health Plan	Age Cohort	ACO/CIN Documents HRSN Screening Results	ACO/ CIN Facilitates Outbound HRSN Referral	ACO/ CIN Closes-the-Loop on HRSN Referral
Arizona Complete Health - Complete Care Plan	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatrics <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:
Banner-University Family Care	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatrics <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:
Molina Healthcare	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatrics <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:
Mercy Care	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatrics <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:
Blue Cross Blue Shield of Arizona Health Choice	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatrics <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:
UnitedHealthcare Community Plan	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatrics <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective Dates:

ACO or CIN Representative Information
By signing the HRSN Delegation Form, the ACO or CIN representative affirms their support for assisting this provider organization in HRSN activities indicated above. The ACO/CIN Representative confirms that they support the organization named on this form in sending and receiving HRSN Referrals.
Organization Representative Signature
ACO/CIN Representative Signature
Date