

MEMBER NAME

DATE OF BIRTH

AHCCCS ID #

ALTCS ENROLLMENT TRANSITION INFORMATION FORM

SENDING CONTRACTOR: \_\_\_\_\_ RECEIVING CONTRACTOR: \_\_\_\_\_

TRANSITION DATE: \_\_\_\_\_ RATE CODE: \_\_\_\_\_

PRIMARY LANGUAGE SPOKEN: \_\_\_\_\_  M OR  F

CONTACT PERSON / RELATIONSHIP: \_\_\_\_\_

(INDICATE IF GUARDIAN, POA, ETC.)

CONTACT PERSON PHONE #: \_\_\_\_\_

PRIMARY HEALTH INSURANCE

MEDICARE #: \_\_\_\_\_ PART  A  B  D

MEDICARE ADVANTAGE –  
PRESCRIPTION DRUG PLAN (PDP): \_\_\_\_\_ SPECIAL NEEDS PLAN:  YES  NO

PDP: \_\_\_\_\_ OTHER: \_\_\_\_\_

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MEMBER LOCATION

CURRENT ADDRESS: \_\_\_\_\_

PHONE  
NUMBER: \_\_\_\_\_

FACILITY NAME (IF APPLICABLE): \_\_\_\_\_

TYPE OF FACILITY:       SKILLED NURSING FACILITY       ASSISTED LIVING FACILITY       BEHAVIORAL HEALTH

ADMISSION DATE: \_\_\_\_\_ SPECIALTY UNIT: \_\_\_\_\_

LEVEL OF CARE: \_\_\_\_\_ ASSISTED LIVING FACILITY (ALF) ROOM AND BOARD AMOUNT: \_\_\_\_\_

MEDICAL INFORMATION

DIAGNOSES: \_\_\_\_\_

PRIMARY CARE PROVIDER (PCP) NAME: \_\_\_\_\_ PCP PHONE #: \_\_\_\_\_

SPECIALISTS (INCLUDING OUT OF AREA)

NAME: \_\_\_\_\_ TYPE: \_\_\_\_\_ PHONE #: \_\_\_\_\_

NAME: \_\_\_\_\_ TYPE: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SCHEDULED APPOINTMENTS/PROCEDURES: \_\_\_\_\_

SPECIAL MEDICATIONS/TREATMENTS: \_\_\_\_\_

CHILDREN'S REHABILITATIVE SERVICES (CRS): \_\_\_\_\_

PENDING PHYSICIAN'S ORDERS NOT YET COMPLETED: \_\_\_\_\_

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**DIALYSIS**

**SITE NAME AND ADDRESS:** \_\_\_\_\_

**DAYS:** M T W TH F SAT SUN **TIME:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**TRANSPORTATION PROVIDED BY:** \_\_\_\_\_

**ASSISTANCE AND/OR TYPE OF TRANSPORTATION REQUIRED:** \_\_\_\_\_

**DURABLE MEDICAL EQUIPMENT (DME)/SUPPLIES (SEE ATTACHED INFORMATION FOR ADDITIONAL DETAILS ON DME/SUPPLIES AS NEEDED)**

**DME:** \_\_\_\_\_  RENTED  OWNED **PROVIDER:** \_\_\_\_\_

**DME:** \_\_\_\_\_  RENTED  OWNED **PROVIDER:** \_\_\_\_\_

**DME:** \_\_\_\_\_  RENTED  OWNED **PROVIDER:** \_\_\_\_\_

**DME:** \_\_\_\_\_  RENTED  OWNED **PROVIDER:** \_\_\_\_\_

**SUPPLIES NEEDED:** \_\_\_\_\_ **PROVIDER:** \_\_\_\_\_

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**PENDING ISSUES REQUIRING FOLLOW-UP:** \_\_\_\_\_

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PENDING GRIEVANCE?

YES

NO

EXPECTED RESOLUTION DATE:

WHAT IS NATURE OF GRIEVANCE?

**HOSPITALIZED MEMBERS (COMPLETE IF MEMBER IS HOSPITALIZED ON DATE FORM IS COMPLETED)**

HOSPITAL:

PHONE:

ADMISSION DATE:

ADMITTING DIAGNOSIS:

INPATIENT TREATMENTS:

EXPECTED DISCHARGE DATE:

DISCHARGE TO:

OTHER COMMENTS:

**DENTAL BENEFIT (COMPLETE FOR ALL MEMBERS))**

ALTCS ROUTINE DENTAL BENEFIT USED:

\$

EMERGENCY DENTAL BENEFIT USED:

\$

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**HOME AND COMMUNITY BASED SERVICES (HCBS) (CHECK ALL THAT APPLY OR ATTACH SERVICE AUTHORIZATIONS FOR DETAILS)**

- |   |                 |               |                  |
|---|-----------------|---------------|------------------|
| <input type="checkbox"/> ADULT DAY HEALTH     | PROVIDER: _____ | PHONE#: _____ | FREQUENCY: _____ |
| <input type="checkbox"/> ATTENDANT CARE       | PROVIDER: _____ | PHONE#: _____ | FREQUENCY: _____ |
| <input type="checkbox"/> HOME DELIVERED MEALS | PROVIDER: _____ | PHONE#: _____ | FREQUENCY: _____ |
| <input type="checkbox"/> HOMEMAKER            | PROVIDER: _____ | PHONE#: _____ | FREQUENCY: _____ |
| <input type="checkbox"/> PERSONAL CARE        | PROVIDER: _____ | PHONE#: _____ | FREQUENCY: _____ |
| <input type="checkbox"/> RESPITE              | PROVIDER: _____ | PHONE#: _____ | FREQUENCY: _____ |
| <input type="checkbox"/> OTHER _____          | PROVIDER: _____ | PHONE#: _____ | FREQUENCY: _____ |
| <input type="checkbox"/> EMERGENCY ALERT      | PROVIDER _____  | PHONE#: _____ |                  |

|  |               |            |  |
|--|---------------|------------|--|
| <input type="checkbox"/> HOME HEALTH NURSING | PROVIDER:     | FREQUENCY: |  |
|  | PHONE#:       |            |  |
|  | PAYER SOURCE: |            |  |
| <input type="checkbox"/> HOME HEALTH AIDE    | PROVIDER:     | FREQUENCY: |  |
|  | PHONE#:       |            |  |
|  | PAYER SOURCE: |            |  |

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**OTHER SERVICES (CHECK ALL THAT APPLY OR ATTACH SERVICE AUTHORIZATIONS FOR DETAILS)**

|                                  |               |            |  |
|----------------------------------|---------------|------------|--|
| <input type="checkbox"/> HOSPICE | PROVIDER:     | FREQUENCY: |  |
|                                  | PHONE#:       |            |  |
|                                  | PAYER SOURCE: |            |  |

**BEHAVIORAL HEALTH (BH)**

BH DIAGNOSIS:

BH MEDICATIONS:

\_\_\_\_\_

\_\_\_\_\_

SPECIAL ASSISTANCE  
SERIOUS MENTAL ILLNESS (SMI)  
YES  NO

CONTACT NAME & RELATION: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

SMI DESIGNATION  
YES  NO

(SMI) OPT OUT YES  NO

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| BH SERVICES/PROVIDERS: |          |         |           |
|------------------------|----------|---------|-----------|
| SERVICE                | PROVIDER | PHONE # | FREQUENCY |
|                        |          |         |           |
|                        |          |         |           |
|                        |          |         |           |
|                        |          |         |           |

LAST DATE OF JUDICIAL REVIEW: \_\_\_\_\_ OUTCOME: \_\_\_\_\_

COURT ORDERED TREATMENT (COT)      NAME ON COURT ORDER: \_\_\_\_\_      EXPIRATION DATE: \_\_\_\_\_

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**REQUIRED ATTACHMENTS AND OTHER TRANSITIONING INFORMATION:**

LAST PERSON-CENTERED SERVICE PLAN  
(CASE MANAGER ASSESSMENT)

CASE MANAGER SUMMARY

LAST QUARTERLY BEHAVIORAL HEALTH CONSULT,  
IF APPLICABLE

ADVANCED DIRECTIVES (LIVING WILLS, POWERS OF ATTORNEY, ETC.),  
IF APPLICABLE

LIST OF MEDICATIONS

EPSDT FORMS, IF APPLICABLE

CONTINGENCY PLAN (SDAC MEMBERS ONLY)

GUARDIAN/CONSERVATORSHIP OR POWER OF  
ATTORNEY/REPRESENTATIVE AUTHORIZATION,  
IF APPLICABLE \_\_\_\_\_

OUTPATIENT ADULT PHYSICAL THERAPY SERVICE  
THE NUMBER OF VISITS RECEIVED FOR CURRENT CONTRACT YEAR

LIFETIME USE OF COMMUNITY TRANSITION SERVICE (CTS)

RESPITE HOURS UTILIZED

BENEFIT COMMUNITY TRANSITION SERVICE

DATE: \_\_\_\_\_

INPATIENT DAYS UTILIZED

CASE MANAGER NAME

PHONE

DATE