______________________	______________________	______________________
Member Name	*Date of Birth*	*AHCCCS ID #*

ALTCS ETI FORM

SENDING PC: ______________________ **RECEIVING PC:** ______________________

TRANSITION DATE: ______________________ **RATE CODE:** ______________________

☐M OR ☐F

PRIMARY LANGUAGE SPOKEN: ______________________

CONTACT PERSON / RELATIONSHIP: ______________________ ______________________

(INDICATE IF GUARDIAN, POA, ETC.)

CONTACT PERSON PHONE #: ______________________

PRIMARY HEALTH INSURANCE

MEDICARE #: ______________________ **PART** ☐A ☐B ☐D

MEDICARE ADVANTAGE -PDP: ______________________ **SNP?** ☐YES ☐NO

PDP: ______________________ **OTHER:** ______________________

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: ______________________ **ALF ROOM AND BOARD AMOUNT:** ______________________

Effective Date: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 10/01/17
Revision Date: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 07/25/17

Member Name ______ *Date of Birth* ______ *AHCCCS ID #* ______

MEDICAL INFORMATION

DIAGNOSES: ______

PCP NAME: ______ **PCP PHONE #:** ______

SPECIALISTS (*INCLUDING OUT OF AREA*)

NAME: ______ **TYPE:** ______ **PHONE #:** ______

NAME: ______ **TYPE:** ______ **PHONE #:** ______

SCHEDULED APPOINTMENTS/PROCEDURES: ______

SPECIAL MEDICATIONS/TREATMENTS: ______

CRS SERVICES: ______

PENDING PHYSICIANS ORDERS NOT YET COMPLETED: ______

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: ______

Effective Date: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 10/01/17
Revision Date: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 07/25/17

Member Name | *Date of Birth* | *AHCCCS ID #*

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:** ______

SUPPLIES NEEDED: ______ **PROVIDER:** ______

SUPPLIES NEEDED: ______ **PROVIDER:** ______

PENDING ISSUES REQUIRING FOLLOW-UP: ______

PENDING GRIEVANCE? ☐ **YES** ☐ **NO** **EXPECTED RESOLUTION DATE:** ______

WHAT IS NATURE OF GRIEVANCE? ______

Member Name ____ *Date of Birth* ____ *AHCCCS ID #* ____

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

HOSPITAL: ____ **PHONE:** ____

ADMISSION DATE: ____ **ADMITTING DIAGNOSIS:** ____

INPATIENT TREATMENTS: ____

EXPECTED DISCHARGE DATE: ____ **D/C TO:** ____

OTHER COMMENTS: ____

DENTAL BENEFIT *(COMPLETE FOR ALL MEMBERS))*

ALTCS ROUTINE DENTAL BENEFIT USED: $ ____

EMERGENCY DENTAL BENEFIT USED: $ ____

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

ADULT DAY HEALTH	**PROVIDER:** ____	**PHONE#:** ____	**FREQUENCY:** ____
☐ **ATTENDANT CARE**	**PROVIDER:** ____	**PHONE#:** ____	**FREQUENCY:** ____
☐ **HOME DELIVERED MEALS**	**PROVIDER:** ____	**PHONE#:** ____	**FREQUENCY:** ____
☐ **HOMEMAKER**	**PROVIDER:** ____	**PHONE#:** ____	**FREQUENCY:** ____

Member Name	*Date of Birth*	*AHCCCS ID #*

☐ **PERSONAL CARE**	**PROVIDER:** ______	**PHONE#:** ______	**FREQUENCY:** ______
☐ **RESPITE**	**PROVIDER:** ______	**PHONE#:** ______	**FREQUENCY:** ______
☐ **OTHER** ______	**PROVIDER:** ______	**PHONE#:** ______	**FREQUENCY:** ______
☐ **EMERGENCY ALERT**	**PROVIDER** ______	**PHONE#:** ______	

☐ **HOME HEALTH NURSING**	**Provider:**	**Frequency:**	
	Phone#:		
	Payer Source:		
☐ **HOME HEALTH AIDE**	**Provider:**	**Frequency:**	
	Phone#:		
	Payer Source		
☐ **HOSPICE**	**Provider:**	**Frequency:**	
	Phone#:		
	Payer Source:		

BEHAVIORAL HEALTH

BH DIAGNOSIS: ______

BH MEDICATIONS: ______

Member Name ________ *Date of Birth* ________ *AHCCCS ID #* ________

BH SERVICES/PROVIDERS:			
SERVICE	PROVIDER	PHONE #	FREQUENCY

LAST DATE OF JUDICIAL REVIEW: ________ OUTCOME: ________

☐ COT ________ NAME ON COURT ORDER: ________ EXPIRATION DATE: ________

REQUIRED ATTACHMENTS AND OTHER TRANSITIONING INFORMATION:

☐ LAST CM ASSESSMENT

☐ CM SUMMARY

Member Name	*Date of Birth*	*AHCCCS ID #*

☐LAST QUARTERLY BEHAVIORAL HEALTH CONSULT, IF APPLICABLE

☐LIST OF MEDICATIONS

☐CONTINGENCY PLAN, IF MEMBER RECEIVING CRITICAL SERVICES

☐OUT-PT ADULT PHYSICAL THERAPY SERVICE. THE NUMBER OF VISITS RECEIVED FOR CURRENT CONTRACT YEAR

☐RESPITE HOURS UTILIZED

☐INPATIENT DAYS UTILIZED

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

☐EPSDT FORMS, IF APPLICABLE

☐GUARDIAN/CONSERVATORSHIP OR POWER OF ATTORNEY, IF APPLICABLE ______________________________________

☐LIFETIME USE OF COMMUNITY TRANSITION SERVICE (CTS)

☐BENEFIT COMMUNITY TRANSITION SERVICE
DATE: ______________________

CASE MANAGER NAME	*PHONE*	*DATE*