State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________________

The following ambulatory services are provided.*

Medically Needy Not Covered

*Description provided on attachment

State/Territory: Arizona

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ________ (NOT COVERED)

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/_/Provided: /_/No limitations /_/With limitations*

2.a.Outpatient hospital services.

/_/Provided: /_/No limitations /_/With limitations*

b.Rural health clinic services and other ambulatory services furnished by a rural health clinic.

/_/Provided: /_/No limitations /_/With limitations*

3. Other laboratory and X-ray services.

/_/ Provided: /_/ No limitations /_/With limitations*

4.a.Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/_/Provided: /_/No limitations /_/With limitations*

b.Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

c.Family planning services and supplies for individuals of childbearing age.

/_/Provided: /_/No limitations /_/With limitations*

*Description provided on attachment.

State/Territory: ARIZONA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s): ______

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ___ No limitations ___ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations ___ With limitations:

*Description provided on attachment.

State/Territory: ARIZONA

Medically Needy
Not Covered

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

__ Provided: __ No limitations __ With limitations*

b. Optometrists' Services

__ Provided: __ No limitations __ With limitations*

c. Chiropractors' Services

__ Provided: __ No limitations __ With limitations*

d. Other Practitioners' Services

__ Provided: __ No limitations __ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__ Provided: __ No limitations __ With limitations*

b. Home health aide services provided by a home health agency.

__ Provided: __ No limitations __ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

__ Provided: __ No limitations __ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

__ Provided: __ No limitations __ With limitations*

*Description provided on attachment.

State/Territory: ARIZONA

Medically Needy
Not Covered

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________________

8. Private duty nursing services.

__ Provided: __ No limitations __ With limitations*

9. Clinic services.

__ Provided: __ No limitations __ With limitations*

10. Dental services.

__ Provided: __ No limitations __ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

__ Provided: __ No limitations __ With limitations*

b. Occupational therapy.

__ Provided: __ No limitations __ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

__ Provided: __ No limitations __ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

__ Provided: __ No limitations __ With limitations*

b. Dentures.

__ Provided: __ No limitations __ With limitations*

*Description provided on attachment.

State/Territory: ARIZONA

Medically Needy
Not Covered

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________________

c. Prosthetic devices.

__ Provided: __ No limitations __ With limitations*

d. Eyeglasses.

__ Provided: __ No limitations __ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

__ Provided: __ No limitations __ With limitations*

b. Screening services.

__ Provided: __ No limitations __ With limitations*

c. Preventive services.

__ Provided: __ No limitations __ With limitations*

d. Rehabilitative services.

__ Provided: __ No limitations __ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

__ Provided: __ No limitations __ With limitations*

b. Skilled nursing facility services.

__ Provided: __ No limitations __ With limitations*

*Description provided on attachment.

State/Territory: ARIZONA

Medically Needy
Not Covered

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

c. Intermediate care facility services.

__ Provided: __ No limitations __ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

__ Provided: __ No limitations __ With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

__ Provided: __ No limitations __ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

__ Provided: __ No limitations __ With limitations*

17. Nurse-midwife services.

__ Provided: __ No limitations __ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

__ Provided: __ No limitations __ With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(Medically Needy Not Covered)

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ___________

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19. Case management services and tuberculosis related services.

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

___ Provided: ___ With limitations*

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

___ Not provided

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

___ Provided +: ___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

___ Provided +: ___ Additional coverage ++ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

___ Provided: ___ No limitations ___ With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

NOT COVERED

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/_/ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Services of Christian Science nurses.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Care and services provided in Christian Science sanitoria.

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/_/ Provided: /_/ No limitations /_/ With limitations*

e. Emergency hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

NOT APPLICABLE

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ______________________

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ Provided _____ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or residnet of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accorance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished at home.

_____ Provided: _____ State Approved (Not Physician) Service Plan Allowed

_____ Services Outside the Home Also Allowed

_____ Limitations Described on Attachment

_____ Not Provided.