ALTCS MEMBER CHANGE REPORT

Member Name	AHCCCS ID:	Date

ALTCS Contractor:	Reported By:	Phone #:
Sent To: ❑ ALTCS Local Office ❑ DHCM ❑ Medical QC Supervisor	DOB:	Customer #:
Verification Attached? ❑ YES ❑ NO	Verification Type: ❑ DE-130 ❑ Case Notes ❑ Other: ________	

PART I - DEMOGRAPHIC/MISCELLANEOUS (SEND DE-701 TO ALTCS LOCAL OFFICE)

❑ **Address Change:** ❑ Residential ❑ Move to Home in Different Fiscal County ❑ Mailing ❑ Move Out of State	**For:** ❑ Representative ❑ Member	Effective Date: ___/___/___
❑ Name ❑ Sex ❑ DOB ❑ Phone # ❑ SSN ❑ DOD ❑ Other:		
Explain Change:		

PART II - PLACEMENT/LIVING ARRANGEMENT (SEND DE-701 TO ALTCS LOCAL OFFICE)

FROM: (previous residence) Enter facility name (if applicable), address and phone number. **TO:** (new residence) Check living arrangement. (Abbreviations in parentheses are used by the ALTCS local offices). Effective date: Indicate effective date of change. Length of Stay: Indicate length of stay and if temporary, enter date. Facility Status: Check facility Status (if applicable). Enter facility name (if applicable), address, and phone number. Enter comments.

FROM:		Phone: ( )	
Address:	City:	State:	Zip Code:

TO: LIVING ARRANGEMENT	EFFECTIVE DATE:	LENGTH OF STAY:	FACILITY STATUS:
❑ NF/ICF ❑ Home ❑ Adult Foster Care Home * ❑ Assisted Living Home * ❑ Assisted Living Center * ❑ Behavioral Health Residential ❑ Behavioral Health Supportive Home	___/___/___	❑ Permanent ❑ Temporary Until: __/__/__ ❑ Unknown	❑ Medicare Certified ❑ Not Medicare Certified ❑ Licensed ❑ Unlicensed ❑ Contracted with PC ❑ Not Contracted with PC
❑ DD Group Home/Adult Developmental Home ❑ Child Developmental Foster Home/Large Group Setting ❑ Alternative Acute Living Arrangement ❑ Loss of Contact ❑ Other ____________________	**NOTE TO LOCAL OFFICE:** To change from Acute to LTC call the Technical Service Center in addition to entering the change in ACE. * If not registered with AHCCCS or licensed by ADHS or OBHL, use Alternative Acute Living Arrangement.		

Facility Name:	Provider ID:	Phone: ( )	
Address:	City:	State:	Zip Code:
Comments:			

Effective Dates: 07/04, 10/07, 01/01, 01/12, 10/13, 01/16, 10/01/17
Revision Dates: 07/04, 10/07, 01/11, 01/12, 05/12, 10/13, 01/16, 07/25/17

Member Name _______________ _AHCCCS ID:_ _______________ _Date_ _______________

PART III - CLIENT STATUS

SEND THE DE-701 TO THE ALTCS LOCAL OFFICE TO REPORT THE FOLLOWING CHANGES:

- ❑ Member requests voluntary withdrawal from ALTCS (DE-130 attached)
- ❑ Change Contract Type from LTC to Acute for retroactive period (refusing services)
- ❑ Temporarily Absent from Arizona ❑ Returned to Arizona
- ❑ Tribal Enrollment Change – DHCM was contacted ❑ On-Reservation ❑ Off-Reservation

SEND THE DE-701 TO DHCM FOR THE FOLLOWING CHANGES:

- ❑ From LTC to Acute– (Attach case notes)
  - ❑ Services not available ❑ Temporarily out of service area
  - ❑ Refusing Services (DE-130 not signed)
- ❑ From Acute to LTC
  - ❑ Services are available ❑ No longer out of service area
  - ❑ No longer Refusing Services

Date From: ___/___/___

Date To: ___/___/___

Comments:

PART IV - CHANGE PC WITHIN MARICOPA COUNTY (SEND DE-701 TO ALTCS LOCAL OFFICE)

❑ Member Requests Enrollment Change to: ____________________________________(Contractor)

REASON:

❑ Erroneous Information/Error ❑ Family Continuity ❑ Lack of Choice ❑ Continuity of Placement

COMMENTS:

PART V - MEDICARE/OTHER HEALTH INSURANCE (SEND DE-701 TO ALTCS LOCAL OFFICE)

Medicare Part A ❑ YES ❑ NO	Effective Date: ___/___/___		Medicare Number:
Medicare Part B ❑ YES ❑ NO	Effective Date: ___/___/___	Disenrollment Date:	______________
Other Insurance ❑ YES ❑ NO	Effective Date: ___/___/___	___/___/___	Policy Number:

INSURANCE CARRIER: ______________

PART - SHARE OF COST (SEND DE-701 TO ALTCS LOCAL OFFICE)

❑ Reduce Share of Cost Due to Death of Member

❑ Other (Specify):

Effective: Month/Year ___/___

PART VII - INCOME/RESOURCE CHANGE (SEND DE-701 TO ALTCS LOCAL OFFICE)

❑ Income ❑ Resources Explain the change:

Source or Type: ______________________________

PART VIII - VENTILATOR STATUS CHANGE/PAS REASSESSMENT REQUEST (SEE FORM INSTRUCTIONS)

- ❑ Ventilator Dependent ❑ Non-Ventilator Dependent Effective date: ______________
- ❑ PAS Reassessment Request – Check Reason for Assessment and provide comment
- ❑ Improvement in functional abilities or medical condition to the extent that the member may no longer be medically eligible. Explain the change in comments.
- ❑ Transitional member now in NF; expected to exceed 90 days: (Complete Part II)
- ❑ Other (Explain):

Comments:

RESPONSE - (COMPLETED BY AHCCCS EMPLOYEE)	
❑ Refer to Part(s) ______________________	❑ Contract Type Change from ________ to ________
❑ Change Completed	Begin date __________ End date __________
Date Completed ____/____/____	❑ SOC increased to $ ________ Effective Date: __/__/
Effective Date ____/____/____	❑ SOC decreased to $ ________ Effective Date: __/__/
❑ Member no longer eligible	❑ Income Changed
Effective Date ____/____/____	❑ Resources Changed
❑ Failed PAS	❑ Member eligible for acute care only
❑ Other Reason ____________	Effective Date ____/____/____
❑ Member still eligible	❑ ALTCS Acute care
❑ Passed PAS Reassessment	❑ Health Plan ______________________
❑ DHCM has determined LTC status should continue	❑ No Action Taken (see comments)
Comments:	
Signature of AHCCCS Staff Person ______________________	Date Returned ____/____/____

An electronic Member Change Report (MCR) shall be sent to AHCCCS to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.).
- To report a change in the member's financial status (or that of his/her household) which may affect their Arizona Long Term Care System (ALTCS) eligibility, including the initiation of the member's spouse as the paid caregiver.
- To report a change in an ALTCS member's placement.
- To report a change in the member's DDD status and request a Pre-Admission Screening (PAS) reassessment.
- To report the closure of a member's service plan for reasons other that financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program).
- To initiate a Contractor change for a member who is Elderly and/or has Physical Disabilities (E/PD) when the member moves into another Contractor's service area in a Home and Community Based (HCB) setting (does not include alternative residential settings).
- To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs.
- To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to a nursing home or Intermediate Care Facility (ICF) and is expected to stay more than 90 continuous days (this request must be sent within 45 days of admission to the institutional setting).
- To request an Acute Care Only determination for a member who has received no Long Term Care (LTC) services for a full calendar month because s/he refuses ALTCS covered services but s/he has not signed a Voluntary Withdrawal. "Refusing" includes being unwilling or unavailable to receive services offered or covered by the Contractor (examples: members is not home whenever provider comes to deliver care, member unwilling to move out of non-contracted alternative residential setting or member temporarily out of contractor's service area). This determination could result in the member being disenrolled from ALTCS if his/her income exceeds 100% of the Federal Benefit Rate.

- To request a change in a member's status from Acute Care Only back to full LTC when the member begins to accept LTC services.

- To request a change in Contract Type when a member has received no LTC services for a full calendar month, due to no LTC service provider being available. This change will not cause a member to be disenrolled.

- To inform ALTCS when a member is temporarily out-of-state (>30 days).

- For Maricopa County E/PD members only – to report the member's request to change Contractors and the need for an enrollment choice.

- To report loss of contact with the member.

NOTE – Members who are temporarily out of the Contractor's service area including out of state, may be provided with LTC services if these are available, in the member's best interests and are approved by the contractor. No AHCCCS services may be provided while a member is outside of the United States.

A hard copy MCR may be needed if, at the time of submission, the member is no longer enrolled with the Contractor that is attempting to send the report.