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| **INSTRUCTIONS:****ALL SECTIONS MUST BE COMPLETED OR MARKED N/A** |
| 1.
 | **Member Name** | **AKA** | **Telephone** |
|  | **AHCCCS ID #** | **DOB** | **Male** [ ]  **Female** [ ]  |
|  | **Rate Code** | **County Name & #** |
|  | **Relinquishing Contractor**  |
|  | **Receiving Contractor**  |
|  | **Medicare Part A** [ ]  **Part B** [ ]  **N/A** [ ]  | **Other Insurance** | **Plan ID #** |
|  | **ALTCS/Tribal ALTCS Application Pending Yes** [ ]  **No** [ ]  | **Date** |
|  | **Diagnosis** | **Secondary Diagnosis** |
|  | **PCP Name** | **Telephone** |
|  | **High Risk Pregnancy Yes** [ ]  **No** [ ]  | **Explain Risk** |
|  | **Pregnancy Estimated Date of Confinement** | **Maternity Provider** | **Telephone** |
|  | **Medications** | **Injectable Yes** [ ]  **No** [ ] **Provider Administrating:** |
|  | **Transplant Yes** [ ]  **No** [ ]  | **Type**  | **Date** | **Facility**  |
|  | **Catastrophic Reinsurance Yes** [ ]  **No** [ ]  | **Diagnosis/High Cost Specialty Drug: Yes**[ ]  **No**[ ]  |
|  | **Specialist Name** | **Type** | **Telephone** |
|  | **Out-of-Area-Appt Yes** [ ]  **No** [ ]  | **Provider** | **Telephone** |
|  | **Outpatient Services Yes** [ ]  **No** [ ]  | **Provider** | **Telephone** |
|  | **Outpatient Adult PT/OT Yes** [ ]  **No** [ ]  | **# of Visits in Current Contract Year**  |
|  | **Home Health Yes** [ ]  **No** [ ]  | **Provider** | **Telephone** |
|  | **Home Health Services** |
|  | **Case Management Yes** [ ]  **No** [ ]  | **Please Explain** |
|  | **Case Manager Name/DCS Case worker** | **Telephone** |
|  | **Contractor/FFS program Care Manager Name** | **Telephone** |
|  | **Inpatient Yes** [ ]  **No** [ ]  | **Facility Name** | **Telephone** |
|  | **SNF Yes** [ ]  **No** [ ]  | **Facility Name** | **Telephone** |
|  | **# of Skilled Nursing Facility (SNF) Days used/benefit year** |
|  | **Residential Yes** [ ]  **No** [ ]  | **Facility Name** | **Telephone** |
|  | **Admitting Diagnosis** |
|  | **Admission Date Expected Discharge Date** | **Expected Discharge Date** |
|  | **Dental Benefit Used ($)****ALTCS \_\_\_\_\_\_ Adult Dental Emergency Benefit \_\_\_\_\_\_\_\_\_** |  |
|  | **High Needs/High Cost (HNHC) Yes** [ ]  **No** [ ]  **Criteria for inclusion in HNHC**  |
|  | **CRS Diagnosis(s) MSIC provider** |
|  | **Behavioral Health Yes** [ ]  **No** [ ]  | **Provider**  | **Telephone** |
|  | **Court Ordered Treatment****Yes** [ ]  **No** [ ] **Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_****COT Oversight Provider** | **Court of Jurisdiction** |
|  | **Member on conditional release from Arizona State Hospital Yes** [ ]  **No** [ ]  |  **Care Manager** | **Telephone** |
|  | **Special Assistance (SMI) Yes** [ ]  **No** [ ]  | **Contact Name & Relation** | **Telephone** |
|  | **(SMI) Designation Yes** [ ]  **No** [ ]  | **(SMI) Opt Out Yes** [ ]  **No** [ ]  |
|  | **Member enrolled in CHP in the last 12 months Yes** [ ]  **No** [ ]  | **If yes, termination date**  |
|  | **HCDM/DR Yes** [ ]  **No** [ ]  | **Name** | **Telephone** |
|  | **Respite Hours Used** |
|  | **Medical Equipment Vendor** | **Telephone**  | **Date** |
|  | **Type of Medical Equipment**  |  **Own** [ ]  **Rent** [ ]  **N /A** [ ]  |
|  | **Medical Foods Yes** [ ]  **No** [ ]  | **Vendor** | **Telephone** |
|  | **End of Life Care Services Yes** [ ]  **No** [ ]  |  |
|  | **Exclusive Pharmacy Yes** [ ]  **No** [ ]  | **Pharmacy** | **Telephone Begin Date** |
|  | **Exclusive Prescriber Yes** [ ]  **No** [ ]  | **Prescriber**  | **Telephone Begin Date** |
|  | **Medication Assisted Treatment (MAT) Yes** [ ]  **No** [ ]  | **Prescriber**  | **Telephone:** |
|  | **Other Care Needs** |  |
|  | **Non-Emergency Medical Transportation Yes** [ ]  **No** [ ]  | **Mode** |
|  | **Date Transportation Needed** | **Destination** |
|  | **Person Completing Form** | **Telephone/Email** |
|  | **Date of Notification to Receiving Contractor** |
|  |
| **Comments or additional information**: |

This information is considered CONFIDENTIAL and disclosure is governed by applicable Federal, State, and Agency regulations. Information on this Form is current as of this notification date. This Form must be completed for all members requiring transition services in accordance with AHCCCS policies: No changes or revisions to this Form are permitted without written approval from AHCCCS.