APPLICATION FOR ENROLLMENT INTO AHCCCS CHILDREN'S REHABILITATIVE SERVICES

Please return application and all required documentation to:
Fax: 602-252-5286
Mail: AHCCCS-CRS Enrollment
801 E. Jefferson St. MD 3500
Phoenix, AZ 85034
For questions contact the CRS Enrollment Unit at: 602-417-4545 or 1-855-333-7828

SECTION 1: APPLICANT INFORMATION

Does the applicant have AHCCCS? ☐ YES ☐ NO AHCCCS Health Plan:
If yes: AHCCCS ID Number: If No: Has an application been submitted? ☐ YES ☐ NO

Child's First Name	M.I.	Child's Last Name

Date of Birth	Age	Gender: ☐ Male ☐ Female	Child's Social Security Number - -

Parent/Representative's First Name	Parent/Representative's Last Name

Relationship to Child: ☐ Parent ☐ Foster Parent ☐ Legal Guardian ☐ Representative ☐ Other:

Parent/Representative's Mailing Address	City	State	Zip Code

Phone Number	Alternate Phone Number

Name of Child's Primary Care Provider	Phone Number
Address, City, State, Zip Code	FAX

List Primary **Diagnosis/Treatment**: **Please send medical records and treatment plan with this form.**
Diagnosis / Treatment
Diagnosis / Treatment
Diagnosis / Treatment

Upcoming Procedures: ☐ YES ☐ NO If Yes, Date of Procedure: Type of Procedure:
Name/Phone Number of Provider Performing Procedure: /
Medications Needing to be Filled within one month: Pharmacy Name/Number: /

SECTION 2: REFERRAL INFORMATION

The individual making the referral discusses the referral with the child's parent/representative listed in Section 1. If expedited request, please contact AHCCCS CRS Enrollment.

Name of Person Making Referral (First, Last)	Address, City, State, Zip Code	Phone Number

Relationship to Child: ☐ Parent ☐ Legal Guardian ☐ Provider ☐ Social Worker ☐ Self ☐ AHCCCS Contractor ☐ Other:

SECTION 3: AUTHORIZATION TO RELEASE INFORMATION (TO BE COMPLETED BY PARENT/REPRESENTATIVE)

AHCCCS cannot share information about a child's CRS enrollment without signed consent from the parent/representative listed in Section 1. Please provide the medical provider or referral source contact information and sign below to authorize AHCCCS to release information about the AHCCCS CRS decision.

Medical Provider/Referral Source Name	Phone Number	FAX

Mailing Address	City	State	Zip Code

I _____(full name of parent/representative listed in Section 1) give my consent to the Arizona Health Care Cost Containment System's (AHCCCS) Children's Rehabilitative Services (CRS) to share any information with the above named provider relating to the receipt of _____(full name of child) CRS application, application processing time, and the final CRS decision.

_____ Signature of Parent/Representative

_____ Date