REQUEST FOR APPLICATION FOR ARIZONA LONG TERM CARE System (ALTCS)

To start the application process, you can call us at **888-621-6880 (toll-free)**. You may also complete this form and return it using one of the methods found on page 4 of this Request for Application.

Customer Information

Customer's Name (Last, First, Middle)	Customer's Date of Birth	
Customer's Social Security Number	☐ Male ☐ Female	
Marital Status ☐ Never Married ☐ Married (including separated if not legally divorced) ☐ Divorced ☐ Widowed Date of spouse's death: _____		
Spouse's Name (Last, First, Middle)	Spouse's Date of Birth	
Spouse's Social Security Number (optional if not applying)		
Customer's Home Address		
City	State	Zip Code
Customer's Mailing Address (if different from home address)		
City	State	Zip Code
Phone Number	E-Mail Address	

Authorized Representative/Spouse and Legal Guardian/Conservator Information

Name of the Customer's Authorized Representative	Relationship to Customer	
Name of the Customer's Legal Guardian/Conservator	Relationship to Customer	
Authorized Representative's Mailing Address		
City	State	Zip Code
Phone Number	E-Mail Address	
Legal Guardian's/Conservator's Mailing Address		
City	State	Zip Code
Phone Number	E-Mail Address	

Customer's Current Living Arrangement

Where is the customer currently residing? ☐ Hospital ☐ Nursing Facility ☐ At Home ☐ Other: _____		Expected Date of Discharge
Name of the Hospital, Assisted Living or Nursing Facility		Phone Number
Hospital, Assisted Living, or Nursing Facility Address		
City	State	Zip Code

Accommodations for Printed Letters

Does the customer, authorized representative, or legal guardian have a visual impairment that requires an alternative format for printed letters?
☐ No ☐ Yes If yes, who needs the accommodation: _____

If yes, what kind of alternative format do you need? Please choose one option:
☐ Readable PDF sent by secure email
☐ Large print: larger print letters sent by U.S. mail will be provided Arial 24 point font.
☐ Other: _____

Additional Questions

Does the customer need help paying for medical expenses from the last three months? Is the customer pregnant or had a pregnancy end in the last 5 months?	☐ Yes ☐ No If yes, what months? _____, _____, _____ ☐ Yes ☐ No
Is the customer receiving services from the DES Division of Developmental Disabilities?	☐ Yes ☐ No If yes, date services began: _____
Prior to the age of 18 was the customer **diagnosed** with any of the following medical conditions? Check all that apply.	☐ Autism ☐ Cerebral Palsy ☐ Intellectual/Cognitive Disability ☐ Seizure Disorder
If the customer is under age of 6, has the customer been **diagnosed** with Developmental Delay?	☐ Yes ☐ No
Is the customer a trustor, trustee, or beneficiary of any type of trust?	☐ Yes ☐ No
Has the customer sold, traded, transferred, or given away any assets within the last five years?	☐ Yes ☐ No

Interview Information: An interview is required to complete the ALTCS application process. The customer is not required to attend the financial interview if the legal guardian/conservator or authorized representative completes the interview for the applicant.

What are the best days and times for you to complete the interview? ☐ Monday Time: _____ ☐ Tuesday Time: _____ ☐ Wednesday Time: _____ ☐ Thursday Time: _____ ☐ Friday Time: _____	
Does the person completing the interview need an interpreter? ☐ Yes ☐ No	If yes, what language? _____

HOW WE WILL USE YOUR INFORMATION

The following information describes how your personal information will be used by Health-e-Arizona Plus, AHCCCS, DES, and their contractors.

- We will use your information, including Social Security number, to computer match with financial institutions, state, local, and federal agencies and our other programs to verify information. Income and verification systems such as the Social Security Administration, State Unemployment Insurance and State Wage may be used. This information may affect eligibility and benefit level.
- Applying and providing information is voluntary, but some information is required to make a determination. For example, you must provide or apply for a Social Security number for every applicant. (Immigrants who are not legally able to obtain a Social Security number are not required to provide one.) Therefore, if personal information is not provided, you may not be eligible for benefits.

Name of Person Completing Form	Phone Number

The person completing this form is the:

- ☐ Customer
- ☐ Spouse of the customer
- ☐ Parent of the customer (if the customer is a minor)

If one of the boxes above is checked, the person completing this form must:

- check the box below; and
- sign this form below.

If one of the boxes above is **NOT** checked, the person completing this form may:

- complete an Authorized Representative form found at: https://www.azahcccs.gov/Members/GetCovered/apply.html;
- attach the completed Authorized Representative form with this request for an application;
- check the box below; and
- sign this form below.

A request for an application may be returned without the completed authorized representative form, checking the box below and signing below, but may cause the application process to take more time.

☐ I agree to allow you to check information sources and use it for this application.

Signature	Date

AHCCCS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

To submit a Request for Application by phone, or for help contact:

Arizona Long Term Care System (ALTCS)

Call (toll-free): 888-621-6880

A completed Request for Application may also be returned by:

- **Fax (toll-free):** 888-507-3313
- **Email:** altcsregistration@azahcccs.gov
- **Mail:** ALTCS
  801 East Jefferson Street
  MD 3900
  Phoenix, AZ 85034

A completed Request for Application may also be taken to a local ALTCS office:

CASA GRANDE
201 East Cottonwood Lane, Suite 2
Casa Grande, Arizona 85122

CHINLE
Tseyi Shopping Center, Hwy 191
Chinle, Arizona, 86503

COTTONWOOD
1500 East Cherry Street, Suite I
Cottonwood, Arizona 86326

FLAGSTAFF
2717 North Fourth Street, Suite 130
Flagstaff, Arizona 86004

KINGMAN
519 East Beale Street, Suite 130
Kingman, Arizona 86401

PHOENIX
801 East Jefferson Street
Phoenix, Arizona 85034

PRESCOTT
3262 Bob Drive, Suite 11
Prescott Valley, Arizona 86314

TUCSON
1010 North Finance Center Drive, Suite 201
Tucson, Arizona 85710

YUMA
3850 West 16th Street, Suite A
Yuma, Arizona 85364

Attention ALTCS Customer:

Please complete the “Authorization to Disclose Protected Health Information to AHCCCS” form. A signature on the form is required by one of the following people:

- Customer;
- Customer’s parent if the customer is under the age of 18; or
- Customer’s Legal Guardian or Legal Representative. Copy of court documents must be provided.

Return this completed form using one of the return options below. For any questions, call (602) 417-6600 or toll-free (888) 621-6880. Please note, returning this form quickly will allow us to assist in getting medical documentation for your application.

Return Options:
Fax (toll-free): 888-507-3313
Email: altcsregistration@azahcccs.gov
Mail: AHCCCS 801 E. Jefferson St. MD 3900 Phoenix, AZ 85034

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO AHCCCS

Return Information to: AHCCCS 801 E. Jefferson St. MD 3900 Phoenix, AZ 85034 Fax: 888-507-3313	AHCCCS Worker Name: Email: Phone Number:

Customer Name:	Date of Birth:
AHCCCS ID Number or PID:	Date of Request:
Customer Address:	Social Security Number (SSN): - - (SSN is optional but may help the provider locate records)

For use by AHCCCS customers/applicants who want a doctor or other entity to give AHCCCS their protected health information.

I give my permission for any health care provider to disclose any of my protected health information to AHCCCS, for the purpose of determining my eligibility for any of the publicly-funded programs administered by AHCCCS. I give AHCCCS permission to share this information with the Arizona Department of Economic Security, Disability Determination Services Administration, if necessary, to determine my disability status.

In addition, by checking these boxes, I specifically authorize the disclosure of the following types of medical records:	
☐	HIV/AIDS and communicable disease related information and/or records
☐	Mental health information and/or records
☐	Genetic testing information and/or records

If the information to be disclosed comes from a school, please fill out this box:

☐ I specifically authorize the holder of my information to disclose all of my educational and evaluation records in its possession to AHCCCS.

By signing this Authorization, I understand that:

- AHCCCS is required by state and federal law to keep confidential the information described above and may only use or disclose that information with my approval, for purposes directly related to the administration of the AHCCCS program, or as otherwise permitted or required by law.

- I also understand that if I refuse to sign or revoke this authorization, AHCCCS may not be able to determine my current or future eligibility for the publicly funded medical assistance programs administered by AHCCCS. As a result, my application for assistance may be denied or the assistance may be discontinued.

- I may **revoke** this authorization, in writing, at any time, by completing an AHCCCS "Revocation of Authorization" form, and sending it to:

  Arizona Health Care Cost Containment System
  Office of Legal Assistance
  Attention: Privacy Officer
  701 E. Jefferson, MD 6200
  Phoenix, AZ 85034
  Phone 602-417-4232
  Fax 1-602-253-9115

Once AHCCCS receives the revocation, this authorization will be revoked, except to the extent that AHCCCS has already taken action in reliance upon this authorization.

Please choose one of the following:

This authorization will expire on:		
☐	Insert specific date:	
☐	Insert specific event:	

The customer's signature is required to get medical records. If the customer is under the age of 18, the signature of the customer's parent is needed. If the customer has a legal guardian or legal representative, the signature of the legal guardian or legal representative is needed.

Signature:	Date:
Printed name of person signing form:	Relationship to Customer:
Printed name of witness (only needed if customer signed with mark):	Signature of witness: