**Exhibit 1620-12**

**Spouse Attendant Care Acknowledgement of Understanding Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Member Name: |  | AHCCCS ID#: |  |

We, the people who have signed on the next page, choose to have Arizona Long Term Care System (ALTCS) pay \_\_\_\_\_\_\_\_\_\_\_\_\_(the spouse) for \_\_\_\_\_\_\_\_\_\_\_\_\_\_’s (the member’s) care. We know and agree that:

* The ALTCS Case Manager will decide the number of hours that will be paid for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s (the member’s) care;
* All services will be medically necessary and cost effective; and
* We cannot have more than 40 hours of Attendant Care (or similar services) in a seven day period.

We know and agree that if \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the spouse) is paid for giving care:

* There will be an increase in the earned income of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the spouse);
* The extra income could cause us to lose benefits from other publicly funded programs; and
* This change in benefits could affect us and/or others in our household.

Publicly funded programs may include but are not limited to the following:

|  |  |  |
| --- | --- | --- |
| **Benefit Type** | **Agency Responsible** | **Phone Number** |
| AHCCCS, ALTCS and/or KidsCare eligibility | AHCCCS  |  |
| Supplemental Security Income (SSI) | Social Security Administration |  |
| Medicare Part D Low Income Subsidy | Social Security Administration |  |
| Food Stamps | Arizona Department of Economic Security |  |
| Temporary Assistance to Needy Families (TANF) | Arizona Department of Economic Security |  |
| General Assistance | Arizona Department of Economic Security |  |
| Housing and Urban Development (HUD) Housing | Local Housing Authority |  |
| Social Security Disability | Social Security Administration |  |
| Qualified Medicare Beneficiary (QMB) | AHCCCS |  |
| Specified Low-Income Medicare Beneficiary (SLMB) | AHCCCS |  |
| Qualified Individual – 1 (QI-1) | AHCCCS |  |
| Other: |  |  |
| Other: |  |  |

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We know it is up to us to get in touch with any agencies from whom anyone in our household receives benefits. We will:

* Talk about how a change in the income for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the spouse) may affect those benefits;
* Talk about this before making a decision to pay \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the spouse) for care; and
* Tell any agency from whom we currently receive benefits of the change in income if/when we decide to pay \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the spouse) for care.

We understand that some or all of our publicly funded benefits could be stopped or reduced. This depends on the amount of income \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the spouse) receives as an ALTCS paid caregiver. We will ask \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s (the member’s) ALTCS case manager for assistance if we need it.

We also know:

* We can change our minds about paying \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the spouse) for care at any time;
* We can decide that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the member) should receive other ALTCS services; and
* These services must be medically necessary and cost effective.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Member:  |  | Date: |  |
| Signature of Spouse: |  | Date: |  |
| Signature of Case Manager: |  | Date: |  |

**Annual Review of Choice for Spouse Attendant Care**

My spouse has been my paid ALTCS caregiver. I wish to continue with that plan. I know that there are other agencies and caregivers who could provide my care. I know that by choosing my spouse, I only get **up to** 40 hours of Attendant Care (or similar services) per week.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Member:  |  | Date: |  |
| Signature of Member:  |  | Date: |  |
| Signature of Member:  |  | Date: |  |
| Signature of Member:  |  | Date: |  |
| Signature of Member:  |  | Date: |  |

cc: Member

 Case file

\*Exhibit 1620-12 is also available in Spanish. See Appendix K, Select ALTCS Case Management Forms in Spanish.

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