Member Name | *Date of Birth* | *AHCCCS ID #*

ALTCS ENROLLMENT TRANSITION INFORMATION FORM

SENDING CONTRACTOR: ______________ **RECEIVING CONTRACTOR:** ______________

TRANSITION DATE: ______________ **RATE CODE:** ______________

PRIMARY LANGUAGE SPOKEN: ______________ ☐M OR ☐F

CONTACT PERSON / RELATIONSHIP: ______________ ______________
(INDICATE IF GUARDIAN, POA, ETC.)

CONTACT PERSON PHONE #: ______________

PRIMARY HEALTH INSURANCE

MEDICARE #: ______________ **PART** ☐A ☐B ☐D

MEDICARE ADVANTAGE – PRESCRIPTION DRUG PLAN (PDP): ______________ **SPECIAL NEEDS PLAN:** ☐YES ☐NO

PDP: ______________ **OTHER:** ______________

Effective Dates: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 10/01/17, 05/20/20
Approval Dates: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 07/25/17, 04/30/20

Member Name ______ *Date of Birth* ______ *AHCCCS ID #* ______

MEMBER LOCATION

CURRENT ADDRESS: ______

PHONE NUMBER: ______

FACILITY NAME ***(IF APPLICABLE)*****:** ______

TYPE OF FACILITY: ☐**SKILLED NURSING FACILITY** ☐**ASSISTED LIVING FACILITY** ☐**BEHAVIORAL HEALTH**

ADMISSION DATE: ______ **SPECIALTY UNIT:** ______

LEVEL OF CARE: ______ **ASSISTED LIVING FACILITY (ALF) ROOM AND BOARD AMOUNT:** ______

MEDICAL INFORMATION

DIAGNOSES: ______

PRIMARY CARE PROVIDER (PCP) NAME: ______ **PCP PHONE #:** ______

SPECIALISTS ***(INCLUDING OUT OF AREA)***

NAME: ______ **TYPE:** ______ **PHONE #:** ______

NAME: ______ **TYPE:** ______ **PHONE #:** ______

SCHEDULED APPOINTMENTS/PROCEDURES: ______

SPECIAL MEDICATIONS/TREATMENTS: ______

Effective Dates: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 10/01/17, 05/20/20
Approval Dates: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 07/25/17, 04/30/20

Member Name	*Date of Birth*	*AHCCCS ID #*

CHILDREN'S REHABILITATIVE SERVICES (CRS): ______

PENDING PHYSICIANS ORDERS NOT YET COMPLETED: ______

DIALYSIS

SITE NAME AND ADDRESS: ______

DAYS: ☐M ☐T ☐W ☐TH ☐F ☐SAT ☐SUN **TIME:** ______ **PHONE NUMBER:** ______

TRANSPORTATION PROVIDED BY: ______

ASSISTANCE AND/OR TYPE OF TRANSPORTATION REQUIRED: ______

DURABLE MEDICAL EQUIPMENT (DME)/SUPPLIES (SEE ATTACHED INFORMATION FOR ADDITIONAL DETAILS ON DME/SUPPLIES AS NEEDED)

DME: ______ ☐ **RENTED** ☐**OWNED** **PROVIDER:** ______

DME: ______ ☐ **RENTED** ☐**OWNED** **PROVIDER:** ______

DME: ______ ☐**RENTED** ☐**OWNED** **PROVIDER:** ______

DME: ______ ☐**RENTED** ☐**OWNED** **PROVIDER:** ______

SUPPLIES NEEDED: ______ **PROVIDER:** ______

SUPPLIES NEEDED: ______ **PROVIDER:** ______

SUPPLIES NEEDED: ______ **PROVIDER:** ______

Effective Dates: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 10/01/17, 05/20/20
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Member Name	*Date of Birth*	*AHCCCS ID #*

PENDING ISSUES REQUIRING FOLLOW-UP: ______________________

____

____

____

____

____

PENDING GRIEVANCE? ☐ **YES** ☐ **NO** **EXPECTED RESOLUTION DATE:** ______________

WHAT IS NATURE OF GRIEVANCE? ______________________

____

____

HOSPITALIZED MEMBERS ***(COMPLETE IF MEMBER IS HOSPITALIZED ON DATE FORM IS COMPLETED)***

HOSPITAL: ______________________ **PHONE:** ______________

ADMISSION DATE: ______________ **ADMITTING DIAGNOSIS:** ______________

INPATIENT TREATMENTS: ______________________

EXPECTED DISCHARGE DATE: ______________ **DISCHARGE TO:** ______________

OTHER COMMENTS: ______________________

____

____

Effective Dates: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 10/01/17, 05/20/20
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____________	____________	____________
Member Name	*Date of Birth*	*AHCCCS ID #*

DENTAL BENEFIT *(COMPLETE FOR ALL MEMBERS))*

ALTCS ROUTINE DENTAL BENEFIT USED: $ ____________

EMERGENCY DENTAL BENEFIT USED: $ ____________

HOME AND COMMUNITY BASED SERVICES (HCBS) *(CHECK ALL THAT APPLY OR ATTACH SERVICE AUTHORIZATIONS FOR DETAILS)*

Service			
☐ ADULT DAY HEALTH	PROVIDER: ____________	PHONE#: ____________	FREQUENCY: ____________
☐ ATTENDANT CARE	PROVIDER: ____________	PHONE#: ____________	FREQUENCY: ____________
☐ HOME DELIVERED MEALS	PROVIDER: ____________	PHONE#: ____________	FREQUENCY: ____________
☐ HOMEMAKER	PROVIDER: ____________	PHONE#: ____________	FREQUENCY: ____________
☐ PERSONAL CARE	PROVIDER: ____________	PHONE#: ____________	FREQUENCY: ____________
☐ RESPITE	PROVIDER: ____________	PHONE#: ____________	FREQUENCY: ____________
☐ OTHER ____________	PROVIDER: ____________	PHONE#: ____________	FREQUENCY: ____________
☐ EMERGENCY ALERT	PROVIDER ____________	PHONE#: ____________	

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Member Name	*Date of Birth*	*AHCCCS ID #*

☐ HOME HEALTH NURSING	Provider:	Frequency:	
	Phone#:		
	Payer Source:		
☐ HOME HEALTH AIDE	Provider:	Frequency:	
	Phone#:		
	Payer Source		

OTHER SERVICES(*CHECK ALL THAT APPLY OR ATTACH SERVICE AUTHORIZATIONS FOR DETAILS*)

☐ HOSPICE	Provider:	Frequency:	
	Phone#:		
	Payer Source:		

BEHAVIORAL HEALTH (BH)

BH DIAGNOSIS: ______________________

BH MEDICATIONS: ______________________

Special Assistance Serious Mental Illness (SMI) Yes ☐ No ☐

Contact Name & Relation: ________________ Telephone:

(SMI) Opt Out Yes ☐ No ☐

SMI Designation Yes ☐ No ☐

Member Name ____________________ *Date of Birth* ____________________ *AHCCCS ID #* ____________________

BH SERVICES/PROVIDERS:			
SERVICE	**PROVIDER**	**PHONE #**	**FREQUENCY**

LAST DATE OF JUDICIAL REVIEW: ____________________ **OUTCOME:** ____________________

☐ **COURT ORDERED TREATMENT (COT)** ____________ **NAME ON COURT ORDER:** ____________________ **EXPIRATION DATE:** ____________________

Member Name	*Date of Birth*	*AHCCCS ID #*

REQUIRED ATTACHMENTS AND OTHER TRANSITIONING INFORMATION:

☐ LAST PERSON-CENTERED SERVICE PLAN (CASE MANAGER ASSESSMENT)

☐LAST QUARTERLY BEHAVIORAL HEALTH CONSULT, IF APPLICABLE

☐LIST OF MEDICATIONS

☐CONTINGENCY PLAN (SDAC MEMBERS ONLY)

☐OUTPATIENT ADULT PHYSICAL THERAPY SERVICE. THE NUMBER OF VISITS RECEIVED FOR CURRENT CONTRACT YEAR

☐RESPITE HOURS UTILIZED

☐INPATIENT DAYS UTILIZED

☐ CASE MANAGER SUMMARY

☐ADVANCED DIRECTIVES (LIVING WILLS, POWERS OF ATTORNEY, ETC.), IF APPLICABLE

☐EPSDT FORMS, IF APPLICABLE

☐GUARDIAN/CONSERVATORSHIP OR POWER OF ATTORNEY/REPRESENTATIVE AUTHORIZATION, IF APPLICABLE ____

☐LIFETIME USE OF COMMUNITY TRANSITION SERVICE (CTS)

☐BENEFIT COMMUNITY TRANSITION SERVICE DATE: ______________________

CASE MANAGER NAME	*PHONE*	*DATE*

Effective Dates: 12/01/06, 10/01/07, 07/01/08, 10/01/10, 10/01/11, 05/01/12, 01/01/16, 10/01/17, 05/20/20
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