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

|  |
| --- |
| **Section A: To Be Completed By The ALTCS Case Manager** |

|  |  |
| --- | --- |
| Contractor: |  |

|  |  |
| --- | --- |
| Extension request: |  |

|  |  |
| --- | --- |
| Current residence/placement: |  |

|  |  |
| --- | --- |
| Diagnosis/condition necessitating this placement: |  |
|  |

|  |  |
| --- | --- |
| Distance from requested Nursing Facility (NF) to nearest family: |  |
|  |

|  |  |
| --- | --- |
| Level of involvement by family: |  |
|  |

|  |  |
| --- | --- |
| Description of facility’s program(s) that makes this placement appropriate for the member: |  |
|  |
|  |

|  |  |
| --- | --- |
| Information about Arizona NFs that were ruled out for this member: |  |
|  |

|  |  |
| --- | --- |
| Discharge plan for member’s return to Arizona placement: |  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| Indicate requested NF: |  |

|  |  |  |
| --- | --- | --- |
|[ ]  **San Juan Manor****806 W. Maple****Farmington, NM 87401** |  |[ ]  **Four Corners Care Ctr****818 N. 400 West****Blanding, UT 84511** |
|[ ]  **Bloomfield Nursing** **803 Hacienda Lane****Bloomfield, NM 87413** |  |[ ]  **Red Rocks Care Ctr.****3720 Church Rock Rd.****Gallup, NM 87301** |
|  |  |  |  |  |
|[ ]  **Hurricane Health & Rehab****416 N State St** **Hurricane, UT 84737-1875** |  |[ ]  **St. George Rehab****1032 E 100 S.** **St. George, UT 84770** |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| ***Primary Care Physician (PCP) Name*** |  | ***AHCCCS Provider ID*** |
| *By signing below the ALTCS Case Manager understands AHCCCS approvals are generally given for six-month intervals. The Case Manager shall submit an ALTCS Out-of-State Placement Request for Renewal if the Out-of-State placement is expected to continue beyond the initial approved time period.* ***Requests for renewals shall be submitted prior to the expiration of the previous approval.*** |
|  |  |  |
| ***ALTCS Case Manager*** |  | ***Date*** |

|  |
| --- |
| **Section B: To Be Completed by AHCCCS** |
|  |
|

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|[ ]  **Approved** |  |  |  |  |  |  |  |  |
|  |  |  | ***From Date*** |  | ***To Date*** |  | ***Name and Title*** |  | ***Date*** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|[ ]  **DENIED** |  |  |  |  |  |  |
|  |  |  | ***DENIAL DATE*** |  | ***AHCCCS MEDICAL DIRECTOR OR DESIGNEE*** |  | ***DATE*** |

 |