POLICY 320-R, ATTACHMENT A
NOTIFICATION OF MEMBER IN NEED OF SPECIAL ASSISTANCE

*A Contractor, TRBHA, provider, or other person qualified to make the determination that determines a member **with a Serious Mental Illness (SMI)** is in need of Special Assistance, in accordance with AMPM Policy 320-R, must notify the AHCCCS Office of Human Rights within five business days of the determination. If the person is not already identified as Special Assistance, notification is required even if someone is involved and assisting the person.*

PART A: PAGE 1 NOTIFICATION (TO BE COMPLETED BY THE CONTRACTOR, TRBHA, PROVIDER OR OTHER PERSON QUALIFIED AND SENT TO THE OFFICE OF HUMAN RIGHTS VIA SECURE E-MAIL TO OHRTS@AZAHCCCS.GOV

THE FOLLOWING PERSON, WHO IS A PERSON DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS (SMI), IS IN NEED OF SPECIAL ASSISTANCE.

MEMBER: FIRST NAME		LAST NAME		DOB		GENDER	Female
RESIDENCE TYPE	Please Select one						
ADDRESS							
CITY		STATE		ZIP CODE		PHONE NUMBER	
GUARDIANSHIP ASSIGNED	Please se	IF GUARDIANSHIP SELECT TYPE	N/A				
SMI?	Please Select	IF NOT SMI DO NOT COMPLETE OR SUBMIT THIS FORM TO OHR					
T/RBHA Contractor	Select one	AHCCCS ID		T XIX	No	GSA (N/A for T/RBHAs)	N/A

BEHAVIORAL HEALTH PROVIDER		SITE NAME			
SITE ADDRESS					
CITY		STATE/ZIP		SITE PHONE	SITE FAX
CASE MANAGER		EMAIL		PHONE	
CLINICAL COORDINATOR		EMAIL		PHONE	
CLINICAL DIRECTOR NAME		EMAIL			

PLEASE SELECT THE CLINICAL BASIS FROM THE CATEGORIES BELOW UNDER WHICH THE PERSON HAS BEEN DETERMINED TO MEET CRITERIA FOR SPECIAL ASSISTANCE

- ☐ COGNITIVE ABILITY
- ☐ INTELLECTUAL CAPACITY (SIGNIFICANTLY DIMINISHED CAPACITY)
- ☐ LANGUAGE BARRIER (AN INABILITY TO COMMUNICATE THAT EXTENDS BEYOND WHAT AN INTERPRETER/TRANSLATOR CAN ADDRESS)
- ☐ MEDICAL ISSUE (INCLUDING, BUT NOT LIMITED TO, SEVERE PSYCHIATRIC SYMPTOMS THAT AFFECT COMMUNICATION/COGNITION)
- ☐ GUARDIANSHIP (AUTOMATICALLY MEETS CRITERIA - Except limited)

PLEASE DETAIL THE SPECIFIC CONDITION(S) THAT SUPPORT THE CLINICAL BASIS SELECTED ABOVE:

PART A: PAGE 2

GRIEVANCE OR APPEAL PENDING	No	**CURRENTLY INPATIENT**	No	**INPATIENT FACILITY & UNIT**	
INPATIENT CONTACT NAME				**IF INPATIENT IS OUTPATIENT AWARE OF NOTIFICATION**	N/A
INPATIENT CONTACT PHONE		**INPATIENT CONTACT EMAIL**			
HOW MANY DAYS INPATIENT IN THE LAST 6 MONTHS?		**TOTAL INPATIENT DAYS SHOULD INCLUDE BOTH MEDICAL AND PSYCHIATRIC AND DATES DO NOT NEED TO BE CONSECUTIVE.**			
Is a Guardian, Relative, or a Friend that is regularly involved with the person and Behavioral Health Provider?	Please Select				
Is the Clinical Team in agreement with the below identified support meeting the Special Assistance Needs?	Please Select				
Is the Member in agreement with the below identified support meeting the Special Assistance Needs?	Please Select				
IF SO, BY WHO (NAME)		**RELATIONSHIP**			
PHONE		**ADDRESS**		**CITY**	**STATE/ZIP**
Is The Person In Need Of Special Assistance Aware That You Are Submitting This Notification?	Please Select				
If Person was not informed please explain below:					
DATE COMPLETED		**BY NAME**			
PHONE NUMBER		**E-MAIL**		**TITLE**	

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PART B: RESPONSE (TO BE COMPLETED BY THE OFFICE OF HUMAN RIGHTS ADMINISTRATION (OHR)							
UPDATED PART B? ☐ YES ☐ NO				IF UPDATED PART B INDICATE DATE OF ORIGINAL PART B			
MEMBER FIRST NAME		MEMBER LAST NAME		DOB		ORIGINAL PART A NOTIFICATION DATE	
PER THE INFORMATION PROVIDED/SUPPLEMENTAL INFORMATION OBTAINED, THE PERSON MEETS THE CRITERIA FOR SPECIAL ASSISTANCE			Please Select One				
IF APPLICABLE LIST ADDITIONAL INFORMATION PROVIDED BELOW:							
IF NO PLEASE SELECT REASON MEMBER DOES NOT MEET CRITERIA			Please Select One				
☐ CHECK HERE IF MEETS CRITERIA DUE TO HAVING GUARDIANSHIP (not limited) AWARDED BY THE STATE OF ARIZONA							
GUARDIAN NAME		ADDRESS					
GUARDIAN PHONE		GUARDIAN EMAIL					
CO-GUARDIAN NAME		CONTACT INFO					
THE FOLLOWING PERSON/AGENCY IS DESIGNATED TO PROVIDE SPECIAL ASSISTANCE:							
☐ OHR	ASSIGNED ADVOCATE			PHONE			
EMAIL							
DATE ASSIGNED							
☐ OTHER PERSON ASSIGNED BY OHR							
FIRST NAME		LAST NAME		RELATIONSHIP			
ADDRESS		CITY		STATE/ZIP		PHONE	
ADDITIONAL INFORMATION IF ANY:							
NOTE: SHOULD ANY CHANGES OCCUR WITH THE IDENTIFIED PERSON IT IS THE RESPONSIBILITY OF THE CLINICAL TEAM TO NOTIFY OHR.							
DATE COMPLETED		BY NAME		TITLE			
PHONE NUMBER		E-MAIL					

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PART C: NOTIFICATION OF CHANGE (TO BE COMPLETED BY THE T/RBHA, PROVIDER OR OTHER PERSON QUALIFIED)							
MEMBER FIRST NAME		MEMBER LAST NAME		DOB		ORIGINAL PART A NOTIFICATION DATE	

ORIGINAL REASON PERSON MET CRITERIA (SEE ORIGINAL PART A)

- ☐ COGNITIVE ABILITY
- ☐ INTELLECTUAL CAPACITY (SIGNIFICANTLY DIMINISHED CAPACITY)
- ☐ LANGUAGE BARRIER (AN INABILITY TO COMMUNICATE THAT EXTENDS BEYOND WHAT AN INTERPRETER/TRANSLATOR CAN ADDRESS)
- ☐ MEDICAL ISSUE (INCLUDING, BUT NOT LIMITED TO, SEVERE PSYCHIATRIC SYMPTOMS THAT AFFECT COMMUNICATION/COGNITION)
- ☐ FULL GUARDIANSHIP (AUTOMATICALLY MEETS CRITERIA)

PLEASE INDICATE THE DATE WHEN THE NEED FOR SPECIAL ASSISTANCE WAS NO LONGER REQUIRED: (PART C TO BE SUBMITTED TO OHR WITHIN TEN (10) BUSINESS DAYS OF THE DETERMINATION)	

THE ABOVE REFERENCED PERSON NO LONGER MEETS THE CRITERIA FOR SPECIAL ASSISTANCE FOR THE FOLLOWING REASON(S):

N/A

WAS THE MEMBER INFORMED, DUE TO A CHANGE IN CIRCUMSTANCES, HE/SHE NO LONGER MEETS THE CRITERIA FOR SPECIAL ASSISTANCE AND UNDERSTANDS THE CHANGE?	N/A
IF OHR WAS MEETING NEEDS, IS ASSIGNED ADVOCATE AWARE A PART C IS BEING COMPLETED?	N/A

IF NO TO EITHER OF THE ABOVE QUESTIONS PLEASE EXPLAIN BELOW:

NOTE: THE PART C CAN ONLY BE PROCESSED AT OHR IF SUBMITTED WITH THE ORIGINAL PART A AND B.

DATE COMPLETED		BY NAME		TITLE	
PHONE NUMBER		E-MAIL			
CLINICAL DIRECTOR NAME		EMAIL			
AGENCY					
				DATE COMPLETED	