AHCCCS
Arizona Health Care Cost Containment System

AMPM POLICY 450, EXHIBIT 450-1

AHCCCS OUT OF STATE PLACEMENT FORM

E-mail to MedicalManagement@AZAHCCCS.gov
DO NOT FAX

Type of Request _____ Date _____

Member Information

First Name _____ Last Name _____

Date of Birth _____ Gender _____ Eligibility Status _____

AHCCCS ID _____ CMDP/DDD/CRS (Select all that apply) ☐ CMDP ☐ DDD ☐ CRS ☐ None

Current Diagnoses: 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

If this is an initial request, where is the member currently located? If this is an update, place "N/A" in the field below.

_____

Contractor or TRBHA

Contractor or TRBHA Name _____

Contractor or TRBHA Contact Name _____ Contractor or TRBHA Contact Phone _____

Contractor/Entity Responsible for Physical Health _____

Attempted Placement

This section only needs to be completed for initial requests. It does not need to be completed for 30-day updates, cancellations, or discharges.

Placement 1

Name

City/State

Level of Care

Reason for Barrier

Placement 2

Name

City/State

Level of Care

Reason for Barrier

Placement 3

Name

City/State

Level of Care

Reason for Barrier

Placement 4

Name

City/State

Level of Care

Reason for Barrier

Out-of-State Placement Information

For initial requests, what is the name of the proposed Out of State Placement?

Placement Address

AHCCCS Provider Registration Number

Level of Care

Clinical Information

Presenting issues that require placement out of state?

How will the proposed placement meet the member's needs (i.e. behavioral, physical, and educational)?

Clinical Information (continued)

What are the treatment goals and objectives?

What are the discharge criteria? What progress has been made toward discharge?

Note any barriers preventing discharge and/or a return to in-state services. What are the strategies to overcome these barriers?

What is being done to address the network gap(s) resulting in the need to place the member out- of- state and when is the network expecting to be sufficient to meet the specific needs of this member?

Clinical Information (continued)

What is the plan and associated time line (including the date of tentative discharge) to return the member to in-state care and services? What aspects of the treatment plan are preparing the member for a less restrictive, community-based environment in-state? Please include a list of in-state placements (contracted and non-contracted) that have been contacted to coordinate in-state placements/services.

Once returned to Arizona, what support services will be put in place to secure continued in-state progress?

Has contact with family been severed? ☐ Yes ☐ No

How are family/natural supports being provided to family/natural supports?

What, if any, services are being provided to family/natural supports?

Disposition

What was the date of admission to out of state placement?

If still out of state, what is the projected discharge date?

What was the discharge date (if applicable)?

Length of stay approved?

Reviewer Information

Contractor or TRBHA/ Credentials/ Title of the person who completed the form/ Date

AHCCCS Reviewer Name/ Credentials/ Title / Date