INSTRUCTIONS: ALL SECTIONS MUST BE COMPLETED OR MARKED N/A.					
1.	Member Name	AKA			Telephone
2.	AHCCCS ID #		DOB		Male □ Female □
3.	Rate Code	County Name & #			
4.	Relinquishing Contractor /RBHA				
5.	Receiving Contractor/RBHA				
6.	Medicare Part A □ Part B □	Other Insurance			Plan ID #
7.	ALTCS Application Pending Yes □ No □		Date		
8.	Diagnosis		Secondary Diagnosis		
9.	PCP Name				Telephone
10.	High Risk Yes □ No	Explain Risk			
11.	Pregnancy EDC	Maternity Provider			Telephone
12.	Special Medications				Injectable Yes □ No □
13.	Transplant Yes □ No □	Type	Date	Facility	
14.	Catastrophic Reinsurance Yes □ No □	Diagnosis			
15.	Specialist Name	Type			Telephone
16.	Out-of-Area-Appt Yes □ No □	Provider			Telephone
17.	Outpatient Services Yes □ No □	Provider			Telephone
18.	Outpatient Adult PT Yes □ No □	# of Visits in Current Contract Year			
19.	Home Health Yes □ No	Provider			Telephone
20.	Home Health Services				
21.	Case Management Yes □ No □	Please Explain			
22.	Case Manager Name				Telephone
23.	Plan Care Manager Name				Telephone
24.	Inpatient Yes □ No	Facility Name			Telephone
25.	SNF Yes □ No □	Facility Name			Telephone
26.	# of SNF Days used/benefit year				
27.	Residential Yes □ No □	Facility Name			Telephone
28.	Admitting Diagnosis				
29.	Admission Date				
30.	Dental Benefit Used ($) ALTCS _____ Adult Dental Emergency Benefit _____		Expected Discharge Date		
31.	High Needs / High Cost Yes □ No □				
32.	CRS Diagnosis(s)				
33.	Behavioral Health Yes □ No □	Provider			Telephone
34.	COT Yes □ No □ Expiration Date _____	Court of Jurisdiction			

Effective Date: 10/01/17, 10/01/18
Revision Dates: 04/98, 4/05, 10/01/10, 10/01/11, 07/01/16, 06/01/17, 06/07/18

35.	Monitored by PSRB Yes □ No □	Care Manager	Telephone:
36.	Special Assistance (SMI) Yes □ No □	Contact Name & Relation:	Telephone:
37.	(SMI) Designation Yes □ No □	(SMI) Opt Out Yes □ No □	
38.	Member enrolled in CMDP in the last 12 months Yes □ No □		If yes, termination date:
39.	Guardian Yes □ No □	Name	Telephone
40.	Respite Hrs Used		
41.	Medical Equipment Vendor	Telephone	Date
42.	Type of Medical Equipment		Telephone
43.	Medical Foods Yes □ No □	Vendor	Own □ Rent □
44.	End of Life Care Services Yes □ No □		
45.	Exclusive Pharmacy Yes □ No □	Pharmacy	Telephone
	Prescriber	Telephone	Begin Date
	Medication Assisted Treatment (MAT) Yes □ No □	If yes, Prescriber Name	If yes, Prescriber Telephone
46.	Other Care Needs		
47.	Non-Emergency Medical Transportation Yes □ No □	Mode	
48.	Date Transportation Needed	Destination	
49.	Person Completing Form		Telephone
50.	Date of Notification to Receiving Contractor		

This information is considered CONFIDENTIAL and disclosure is governed by applicable Federal, State, and Agency regulations. Information on this Form is current as of this notification date. This Form must be completed for all members requiring transition services in accordance with AHCCCS policies: No changes or revisions to this Form are permitted without written approval from AHCCCS.

Effective Date: 10/01/17, 10/01/18
Revision Dates: 04/98, 4/05, 10/01/10, 10/01/11, 07/01/16, 06/01/17, 06/07/18