



INSTRUCTIONS:

ALL SECTIONS MUST BE COMPLETED OR MARKED N/A.

1.	Member Name	AKA	Telephone
2.	AHCCCS ID #	DOB	Male <input type="checkbox"/> Female <input type="checkbox"/>
3.	Rate Code	County Name & #	
4.	Relinquishing Contractor /RBHA		
5.	Receiving Contractor/RBHA		
6.	Medicare Part A <input type="checkbox"/> Part B <input type="checkbox"/>	Other Insurance	Plan ID #
7.	ALTCS Application Pending Yes <input type="checkbox"/> No <input type="checkbox"/>	Date	
8.	Diagnosis	Secondary Diagnosis	
9.	PCP Name	Telephone	
10.	High Risk Yes <input type="checkbox"/> No <input type="checkbox"/>	Explain Risk	
11.	Pregnancy EDC	Maternity Provider	Telephone
12.	Special Medications	Injectable Yes <input type="checkbox"/> No <input type="checkbox"/>	
13.	Transplant Yes <input type="checkbox"/> No <input type="checkbox"/>	Type	Date Facility
14.	Catastrophic Reinsurance Yes <input type="checkbox"/> No <input type="checkbox"/>	Diagnosis	
15.	Specialist Name	Type	Telephone
16.	Out-of-Area-Appt Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
17.	Outpatient Services Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
18.	Outpatient Adult PT Yes <input type="checkbox"/> No <input type="checkbox"/>	# of Visits in Current Contract Year	
19.	Home Health Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
20.	Home Health Services		
21.	Case Management Yes <input type="checkbox"/> No <input type="checkbox"/>	Please Explain	
22.	Case Manager Name	Telephone	
23.	Plan Care Manager Name	Telephone	
24.	Inpatient Yes <input type="checkbox"/> No <input type="checkbox"/>	Facility Name	Telephone
25.	SNF Yes <input type="checkbox"/> No <input type="checkbox"/>	Facility Name	Telephone
26.	# of SNF Days used/benefit year		
27.	Residential Yes <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/> No <input type="checkbox"/>		
32.	CRS Diagnosis(s)		
33.	Behavioral Health Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
34.	COT Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date _____	Court of Jurisdiction	



520, ATTACHMENT A - ENROLLMENT TRANSITION INFORMATION (ETI) FORM

35.	Monitored by PSRB Yes <input type="checkbox"/> No <input type="checkbox"/>	Care Manager	Telephone:
36.	Special Assistance (SMI) Yes <input type="checkbox"/> No <input type="checkbox"/>	Contact Name & Relation:	Telephone:
37.	(SMI) Designation Yes <input type="checkbox"/> No <input type="checkbox"/>	(SMI) Opt Out Yes <input type="checkbox"/> No <input type="checkbox"/>	
38.	Member enrolled in CMDP in the last 12 months Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, termination date:
39.	Guardian Yes <input type="checkbox"/> No <input type="checkbox"/>	Name	Telephone
40.	Respite Hrs Used		
41.	Medical Equipment Vendor	Telephone	Date
42.	Type of Medical Equipment		Telephone
43.	Medical Foods Yes <input type="checkbox"/> No <input type="checkbox"/>	Vendor	Own <input type="checkbox"/> Rent <input type="checkbox"/>
44.	End of Life Care Services Yes <input type="checkbox"/> No <input type="checkbox"/>		
45.	Exclusive Pharmacy Yes <input type="checkbox"/> No <input type="checkbox"/>	Pharmacy	Telephone
	Prescriber	Telephone	Begin Date
	Medication Assisted Treatment (MAT) Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, Prescriber Name	If yes, Prescriber Telephone
46.	Other Care Needs		
47.	Non-Emergency Medical Transportation Yes <input type="checkbox"/> No <input type="checkbox"/>	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.