Informational Packet & Application
Arizona Long Term Care System (ALTCS)

Table of Contents:

What is ALTCS?

ALTCS is the State of Arizona's Medicaid program that provides long-term care services, at little or no cost, to financially and medically eligible Arizona residents who are 65 or older, blind, or disabled and need ongoing services at a nursing facility level of care.

However, program participants do not have to reside in a nursing home. Many ALTCS participants live in their homes or an assisted living facility and receive needed in-home services.

AHCCCS contracts with several program contractors to provide long-term care services. An ALTCS program contractor works like a Health Maintenance Organization (HMO). The program contractor works with doctors, nursing homes, assisted living facilities, hospitals, pharmacies, specialists, etc., to provide care. You will also be assigned a case manager who will coordinate your care.

In addition to the services listed above, people who qualify for long-term care can receive services such as:

- Nursing Facility
- Hospice
- Attendant Care
- Assisted Living Facility
- Adult Day Care Health Services
- Home Health Services, such as nursing services, home health aide
- Home Delivered Meals
- Case Management
- Dental Services (up to $1000 per contract year)

Note: This is a partial list of covered services

All information in this document originated from AHCCCS website: https://www.azahcccs.gov/

How to Apply for Arizona Long Term Care (ALTCS)

New to Arizona? A few notes:

- To qualify, applicants must be a resident of Arizona.
- Even if Medicaid covers the applicant in another state, they must still apply for ALTCS benefits.

To start the application process for Long Term Care benefits, you must first complete the **"Request for Application for ALTCS"** to proceed, which you will find on page 5 of this document.

Questions?

If you have questions about the ALTCS program or the application process, please don't hesitate to call or email us. We are happy to help!

CHRISTIAN CARE COTTONWOOD

PH: 928-634-7571
E: Cottonwood@ChristianCare.org

Cottonwood ALTCS Office

1500 East Cherry Street, Suite I
Cottonwood, Arizona 86326
Note: Cottonwood ALTCS staff are sharing space at the DES office.

Phone: 888-621-6880

Applications may also be submitted to: **altcsregistration@azahcccs.gov**

Remember, the **"Request for Application for ALTCS"** form DE-101 *must be completed first* to begin the application process. (Form attached, begins on page 5 of this document).

All information in this document originated from AHCCCS website: https://www.azahcccs.gov/

Filing an Application for the Arizona Long Term Care System (ALTCS)

What is ALTCS?

ALTCS is the State of Arizona's Medicaid program that provides long term care services, at little or no cost, to financially and medically eligible Arizona residents who are aged, blind, disabled, or have a developmental disability.

This information sheet provides general information about the ALTCS application process and includes basic program requirements about residency, age, disability, and citizenship status, as well as general guidelines for financial eligibility which includes resources and income. You must also meet medical eligibility requirements. This is a guide only. Additional information sheets about Community Spouse rules (that apply when you are legally married), trusts and transfers are available upon request. **For more specific questions, contact ALTCS toll-free at (888) 621-6880.**

How do I apply for ALTCS?

- To apply, you must complete an application.
- To start an application, call ALTCS toll-free at (888) 621-6880.
- Another person can act on your behalf during the application process.
- You will need to provide documents to show that you meet financial and non-financial eligibility requirements.
- You must be determined as needing a nursing home level of care.

What are the Non-Financial Eligibility Requirements?

To be eligible for ALTCS, you must:

- Be determined in need of a nursing home level of care as determined by AHCCCS;
- Be a citizen or qualified immigrant;
- Have a Social Security Number (SSN) or apply for one;
- Be an Arizona resident;
- Apply for all cash benefits that you may be entitled to, such as Pensions or VA benefits;
- Live in an approved living arrangement, such as your own home, or an AHCCCS certified nursing facility or assisted living facility.

How are Resources Treated?

For single applicants, countable resources cannot be more than $2,000. If you are legally married, you may be able to set aside some of your resources for the needs of your spouse, so long as your spouse is not living in a medical facility. If you are married, please ask for a Community Spouse Information Sheet.

Countable Resources	Resources That We Do Not Count
• Checking, savings, and credit union accounts • Real property that you do not live in • Cash value of some life insurance policies • Cash, stocks, bonds, certificates of deposits • Non-exempt vehicles	• Your home that you live in, unless it is held in a trust • One vehicle • Burial plots and irrevocable burial plans • $1500 designated for burial • Household and personal belongings • Certain financial accounts that are excluded by federal law. Examples include qualified ABLE accounts, Flexible Spending Arrangements (FSA), and 530 Coverdell Education Savings Accounts.

If your resources are over $2,000, and you are under the age of 65, you may still be able to qualify by setting up a special type of trust. Please ask for the Special Treatment Trust Information Sheet.

How is my Income Treated?

Income that we count includes, but is not limited to, wages, Social Security, Supplemental Security Income and disability or retirement pensions.

The ALTCS gross monthly income limit is $2,742 (effective January 1, 2023) for an individual. If you are married, ask for a Community Spouse Information Sheet. If your income is over the limit, you may still be able to qualify by setting up a special type of trust. If you are over income, ask for a Special Treatment Trust Information Sheet.

Will I Have to Pay Any of My Income Toward the Cost of My Care?

Once you have been determined eligible for ALTCS, a calculation will be made to determine if, or how much, you will need to pay towards the cost of your nursing home or home and community-based services. This amount is called the Share of Cost. Your monthly gross income will be totaled and then the following deductions may be allowed:

- A personal needs allowance;
- A Community Spouse allowance for the needs of your spouse still living in the home;
- A family allowance for any dependents living in your home;
- A home maintenance allowance if you are in a nursing home but will go home within 6 months;
- Your medical insurance premiums; and
- Medical expenses that ALTCS does not pay for like hearing aids, eyeglasses and dental care.

How does ALTCS Determine if I am Medically Eligible?

Once you have been determined financially eligible, a registered nurse or social worker will determine if you are medically eligible in a face-to-face interview. To meet medical requirements, you must be at immediate risk of institutionalization in a nursing facility or intermediate care facility for individuals with intellectual disabilities (you must require that level of care, but you do not need to reside in a facility).

What are the Different Types of ALTCS Services?

Once you have been determined eligible for ALTCS services, you will be enrolled with a Program Contractor and assigned to a case manager. The case manager will meet with you and your family to develop a service plan. Covered services may include the following:

- Institutional Care in a Nursing Facility;
- Home and Community Based Services, combining out-patient and in-home care;
- Medical Services, such as Doctor's office visits and prescriptions (prescription coverage is limited for people with Medicare);
- Behavioral health services;
- Preventive and well care for children; and
- Hospice services.

If you have additional questions, contact your Benefits and Eligibility Specialist, or contact ALTCS toll-free at (888) 621-6880. Additional contact information for ALTCS can be found by going online to: https://www.azahcccs.gov/members/ALTCSlocations.html

For more information, go to the following site on the Internet: https://azahcccs.gov/resources/guidesmanualspolicies/eligibilitypolicy/eligibilitypolicymanual/index.html

Request For Application For Arizona Long Term Care System (ALTCS)

Customer Address:

To start the application process, you can call us at **888-621-6880 (toll-free)**. You may also complete this form and return it using one of the methods found on page 4 of this Request for Application.

Customer Information

Customer's Legal Name (First, Middle Initial, Last, Suffix):	Customer's Date of Birth:
Customer's Social Security Number:	☐ Male ☐ Female
Marital Status: ☐ Never Married ☐ Married (including separated if not legally divorced) ☐ Divorced ☐ Widowed Date of spouse's death: _____	
Spouse's Legal Name (First, Middle Initial, Last, Suffix):	Spouse's Date of Birth:
Spouse's Social Security Number (optional if not applying):	
Customer's Home Address:	Customer's Mailing Address (if different from home address):
Phone Number:	E-mail Address:

Authorized Representative/Spouse and Legal Guardian/Conservator Information

Name of the Customer's Authorized Representative:		Relationship to Customer:
Representative Date of Birth (optional):	Name of the Representative Organization (when applicable):	
Name of the Customer's Legal Guardian/Conservator:		Relationship to Customer:
Authorized Representative's Mailing Address:		
City:	State:	ZIP Code:

Phone Number:	E-mail Address:	
Legal Guardian's/Conservator's Mailing Address:		
City:	State:	ZIP Code:
Phone Number:	E-mail Address:	

Customer's Current Living Arrangement

Where is the customer currently residing? ☐ Hospital ☐ Nursing Facility ☐ At Home ☐ Other: _____	Date Admitted:	Expected Date of Discharge:
Name of the Hospital, Assisted Living or Nursing Facility:		Phone Number:
Hospital, Assisted Living, or Nursing Facility Address:		
City:	State:	ZIP Code:

Accommodations for Printed Letters

Does the customer, authorized representative, or legal guardian have a visual impairment that requires an alternative format for printed letters?
☐ No ☐ Yes If yes, who needs the accommodation?

If yes, what kind of alternative format do you need? Please choose one option:
☐ Readable PDF sent by secure email
☐ Large print: larger print letters sent by U.S. mail will be provided Arial 24-point font.
☐ Other: _____

Additional Questions

Does the customer need help paying for medical expenses from the last three months? Is the customer pregnant or had a pregnancy end in the last 5 months?	☐ Yes ☐ No If yes, what months? , ☐ Yes ☐ No
Is the customer receiving services from the DES Division of Developmental Disabilities?	☐ Yes ☐ No If yes, date services began:
Prior to the age of 18 was the customer **diagnosed** with any of the following medical conditions? Check all that apply.	☐ Autism ☐ Cerebral Palsy ☐ Intellectual/Cognitive Disability ☐ Down syndrome ☐ Seizure Disorder
If the customer is under the age of 6, has the customer been **diagnosed** with Developmental Delay?	☐ Yes ☐ No
Is the customer a trustor, trustee, or beneficiary of any type of trust?	☐ Yes ☐ No
Has the customer sold, traded, transferred, or given away any assets within the last five years?	☐ Yes ☐ No

Interview Information: An interview is required to complete the ALTCS application process. The customer is not required to attend the financial interview if the legal guardian/conservator or authorized representative completes the interview for the customer.

What are the best days and times for you to complete the interview?	
☐ Monday Time: _____ ☐ Tuesday Time: _____ ☐ Wednesday Time: _____ ☐ Thursday Time: _____ ☐ Friday Time: _____	
Does the person completing the interview need an interpreter? ☐ Yes ☐ No	If yes, what language? _____

How We Will Use Your Information

The following information describes how your personal information will be used by Health-e-Arizona Plus, AHCCCS, DES, and their contractors.

- We will use your information, including Social Security number, to computer match with financial institutions, state, local, and federal agencies, and our other programs to verify information. Income and verification systems such as the Social Security Administration, State Unemployment Insurance, and State Wage may be used. This information may affect eligibility and benefit level.
- Applying and providing information is voluntary, but some information is required to make a determination. For example, you must provide or apply for a Social Security number for every applicant. (Immigrants who are not legally able to obtain a Social Security number are not required to provide one.) Therefore, if personal information is not provided, you may not be eligible for benefits.

Name of Person Completing Form:	Phone Number:

The person completing this form is the:

☐ Customer
☐ Spouse of the customer
☐ Parent of the customer (if the customer is a minor)

If one of the boxes above is checked, the person completing this form must:

- check the on the next page; and
- sign this form on the next page.

If one of the boxes above is **NOT** checked, the person completing this form may:

- complete an Authorized Representative form found at: https://www.azahcccs.gov/Members/GetCovered/apply.html;
- attach the completed Authorized Representative form with this request for an application;
- check the box on the next page; and
- sign this form on the next page.

A request for an application may be returned without the completed authorized representative form, checking the box below and signing below, but may cause the application process to take more time.

☐ I agree to allow you to check information sources and use it for this application.

Signature	Date

AHCCCS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

To submit a Request for Application by phone, or for help contact:

Arizona Long Term Care System (ALTCS)

Call (toll-free): 888-621-6880

A completed Request for Application may also be returned by:

- **Fax (toll-free):** 888-507-3313
- **E-mail:** altcsregistration@azahcccs.gov
- **Mail:** ALTCS
  801 E Jefferson St
  MD 3900
  Phoenix AZ 85034

A completed Request for Application may also be taken to a local ALTCS office:

CHINLE Tseyi Shopping Center Hwy 191 Chinle AZ 86503	**PRESCOTT** 3262 Bob Dr Ste 11 Prescott Valley AZ 86314
FLAGSTAFF 2717 N Fourth St Ste 130 Flagstaff AZ 86004	**TUCSON** 7202 E Rosewood St Ste 125 Tucson AZ 85710
KINGMAN 2400 Airway Ave Kingman AZ 86409	**YUMA** 1800 E Palo Verde St Yuma AZ 85365
PHOENIX 801 E Jefferson St Phoenix AZ 85034	

Authorization To Disclose Protected Health Information To AHCCCS

Attention ALTCS Customer:

Please complete the “Authorization to Disclose Protected Health Information to AHCCCS” form. A signature on the form is required by one of the following people:

- Customer;
- Customer’s parent if the customer is under the age of 18; or
- Customer’s Legal Guardian or Legal Representative. Copy of court documents must be provided.

Return this completed form using one of the return options below. For any questions, call (602) 417-6600 or toll-free (888) 621-6880. Please note, returning this form quickly will allow us to assist in getting medical documentation for your application.

Return Options:
Fax (toll-free): 888-507-3313
E-mail: altcsregistration@azahcccs.gov
Mail: AHCCCS
801 E Jefferson St
MD 3900
Phoenix AZ 85034

Authorization To Disclose Protected Health Information To AHCCCS

Return Information to: AHCCCS 801 E Jefferson St MD 3900 Phoenix AZ 85034 Fax: 888-507-3313	AHCCCS Worker Name: E-mail: Phone Number:

Customer Name:	Date of Birth:
AHCCCS ID Number or PID:	Date of Request:
Customer Address:	Social Security Number (SSN): (SSN is optional but may help the provider locate records)

For use by AHCCCS customers/applicants who want a doctor or other entity to give AHCCCS their protected health information.

I give my permission for any health care provider to disclose any of my protected health information to AHCCCS, for the purpose of determining my eligibility for any of the publicly-funded programs administered by AHCCCS. I give AHCCCS permission to share this information with the Arizona Department of Economic Security, Disability Determination Services Administration, if necessary, to determine my disability status.

In addition, by checking these boxes, I specifically authorize the disclosure of the following types of medical records:	
Medical Records	
☐	HIV/AIDS and communicable disease related information and/or records
☐	Mental health information and/or records
☐	Genetic testing information and/or records
School Records	
☐	Educational and evaluation records

By signing this Authorization, I understand that:

- AHCCCS is required by state and federal law to keep confidential the information described above and may only use or disclose that information with my approval, for purposes directly related to the administration of the AHCCCS program, or as otherwise permitted or required by law.

- I also understand that if I revoke this authorization or refuse to sign, AHCCCS may not be able to determine my current or future eligibility for the publicly funded medical assistance programs administered by AHCCCS. As a result, my application for assistance may be denied or the assistance may be discontinued.

- I may revoke this authorization at any time, in writing, by phone, or fax to:
  Arizona Health Care Cost Containment System
  Office of the General Counsel
  Attention: Privacy Officer
  801 E Jefferson St, MD 6200
  PO Box 25520
  Phoenix AZ 85034
  Phone 602-417-4455
  Fax 1-602-253-9115

Once AHCCCS receives the revocation, this authorization will be revoked, except to the extent that AHCCCS has already taken action in reliance upon this authorization.

By checking the box below, I revoke this authorization upon the following date or event.

This authorization will expire on:		
☐	Insert specific date:	_____
☐	Insert specific event:	_____

The customer's signature is required to get medical records. If the customer is under the age of 18, the signature of the customer's parent is needed. If the customer has a legal guardian or legal representative, the signature of the legal guardian or legal representative is needed.

SIGNATURE:	DATE:
PRINTED NAME OF PERSON SIGNING FORM:	RELATIONSHIP TO CUSTOMER:
PRINTED NAME OF WITNESS (ONLY NEEDED IF CUSTOMER SIGNED WITH MARK):	SIGNATURE OF WITNESS: