

ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program/Newborn Intensive Care Program
Request for Participation, Page 2 of 2

Place required label here

PLEASE PRINT

FAMILY INFORMATION

1. Infant's Last Name	2. Alias Last Name	3. Suffix	4. First Name	5. MI	6. Gender M F U	7. DOB
8. Mother's Last Name		9. Mother's First Name		10. MI	11. Current Hospital	

The State of Arizona has established a High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) to provide a system of *Transportation, Hospital, Medical, and Follow-up* for critically ill newborns whose parents reside in Arizona. This program also assists families when needed to cope with catastrophic costs related to newborn intensive care.

I REQUEST THE FOLLOWING LEVEL OF PARTICIPATION:

- FULL (Includes financial assistance)** - I request participation in the High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) which may include transport, inpatient hospital care, and community home nursing. I am requesting financial assistance, if needed, and I understand that HRPP/NICP is the payor of last resort. I agree to submit all necessary documents on behalf of my child for purposes of collection from third party payors and shall retain no insurance proceeds from claims intended as payment for services provided. **I agree to enroll my infant on my third party and/or AHCCCS plan, if eligible, within 30 days from infant's date of birth, and understand that failure to do so will result in HRPP/NICP financial assistance being denied. I agree to complete the HRPP/NICP Financial Worksheet and Financial Questionnaire forms and to fulfill any HRPP/NICP family liability.**
- PARTIAL (No financial assistance)** - I request participation in the High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) which may include transport, inpatient hospital care, and community home nursing but *do not* wish to apply for or receive financial assistance. *I shall be liable for all transport, hospital and medical charges incurred. I understand that I may request a change in my level of participation during the first sixty (60) days after the birth of my child.*
- PARTIAL / LATE ENROLLMENT (No financial assistance)** - I request participation in the follow-up provided by the High Risk Perinatal Program/Newborn Intensive Care Program (community home nursing). I reside in the State of Arizona and my child meets HRPP/NICP eligibility criteria.

- Reason:** Parent originally declined participation Enrollment Hospital never offered program
 Sibling of eligible infant Out of state NICU

I authorize the release of any necessary medical, social and financial information held by any institution or individual that provided newborn services to my child to the Arizona Department of Health Services (ADHS) and to their contracted providers for provider quality management purposes.

I agree to submit my child's NICP Enrollment forms, Request for Participation and Financial Worksheet & Questionnaire (if applicable), to the Hospital NICP Liaison within thirty (30) days from the date my child is eligible for the NICP program. Failure to do so may result in loss of eligibility for financial assistance.

 Signature of Parent/Guardian/Responsible Party Requesting Full or Partial Participation _____
Date

I CERTIFY THAT THIS CHILD MEETS THE ENROLLMENT CRITERIA OF THE NICP

 Signature of Authorized Hospital/Follow-up Representative _____
Date

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