

Instructions for this Application Process

The focus of Children's Rehabilitative Services (CRS) is to improve the quality of life for children by providing family-centered medical treatment, rehabilitation, and related support services to enrolled individuals who have certain medical, handicapping, or potentially handicapping conditions.

To be eligible for CRS, the child or youth must:

- Be a U.S. Citizen
- Be an Arizona resident under age 21 years of age
- Have an identified CRS physical disability, chronic illness, or medical condition that is potentially disabling

To be enrolled in CRS, the child or youth must be currently enrolled in Arizona Health Care Cost Containment System (AHCCCS).

Due to state funding cuts, applications will only be processed if the applicant is enrolled in AHCCCS. To enroll in AHCCCS, call AHCCCS toll free at 1-877-764-5437 or go to <http://www.azahcccs.gov/applicants/application/AcuteCare.aspx> to get an application.

Anyone, including doctors, nurses, patients or friends may refer a child to CRS.

How to Apply

Step 1: Review Application Checklist and complete forms as instructed
If you need help completing the forms, call the Eligibility and Enrollment specialist at your nearest clinic or the statewide phone number below.

Step 2: Return Application and all required documentation to:

Mail: APIPA-CRS
Attn: Eligibility and Enrollment
PO Box 33320
Phoenix, AZ 85067-3320

Fax: 1- 866-623-1692

Drop off at nearest clinic:

Clinic	Location	Phone Numbers
Flagstaff	1200 N. Beaver Street Flagstaff, AZ 86001	(928) 773-2054 1-800-232-1018 toll free
Phoenix	124 W Thomas Road Phoenix, AZ 85013	(602) 406-6400 1-800-392-2222 toll free
Tucson	2600 N. Wyatt Drive Tucson, AZ 85712	(520) 324-5437 1-800-231-8261 toll free
Yuma	2400 Avenue A Yuma, Arizona 86364	(928) 336-7095 1-800-837-7309 toll free Fax (928) 336-7497
Statewide		1-866-275-5576 toll free TDD 1-800-367-8939

CRS REFERRAL/APPLICATION

AHCCCS Health Plan [] NO [] YES If yes, AHCCCS ID # _____ AHCCCS Health Plan: _____

CHILD'S NAME (Last, First, Middle)		ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
DATE OF BIRTH (mo/day/yr) ____ / ____ / ____	CHILD'S SOCIAL SECURITY NUMBER:		RACE <input type="checkbox"/> American Indian or Alaskan Native (I) <input type="checkbox"/> Asian or Pacific Islander (A) <input type="checkbox"/> Black (B) <input type="checkbox"/> Caucasian (C)		
	PREFERRED LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No			
PARENT OR GUARDIAN (Last Name, First Name)			RELATIONSHIP TO CHILD <input type="checkbox"/> Natural Parent (s) <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster <input type="checkbox"/> Other		
CHILD'S ADDRESS	STREET	CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS	STREET	CITY	STATE	ZIP CODE	
HOME PHONE () () ()	MESSAGE /CELL PHONE () () ()	WORK PHONE () () ()	E-MAIL ADDRESS		
CHILD'S Primary Care Practitioner (Address required)					
NAME: ADDRESS, CITY, STATE, ZIP:			PHONE NUMBER: () () ()		
REFERRED BY: (Name, Address, Phone) (This individual verifies that the child's parent/guardian has been notified about this referral.) NAME: _____ PHONE NUMBER: () () () ADDRESS, CITY, STATE, ZIP:			RELATIONSHIP TO CHILD <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Physician <input type="checkbox"/> Social Worker <input type="checkbox"/> Self <input type="checkbox"/> Health Plan <input type="checkbox"/> Other If other, explain:		
REASON FOR REFERRAL:					
LIST PRIMARY DIAGNOSES (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, <u>PLEASE SEND MEDICAL RECORDS WITH THIS FORM.</u>					
1)	2)	3)			
4)	5)	6)			
LIST ANY KNOWN ALLERGIES					
1)	2)	3)			
4)	5)	6)			
HAS CHILD RECEIVED CRS SERVICES BEFORE? : <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT YEAR? _____ WHERE? _____					
WHO COMPLETED THIS FORM NAME: _____ PHONE () () () ADDRESS: _____			RELATIONSHIP TO CHILD <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Physician <input type="checkbox"/> Social Worker <input type="checkbox"/> Self <input type="checkbox"/> Health Plan <input type="checkbox"/> Other If other, explain:		

Before you mail your forms, check this list!!

To speed up your application, have you included?

- Referral/Application - Form 1-A (required)
- Medical records from your doctor to support the CRS condition