Application For AHCCCS Medical Assistance and Medicare Savings Programs

You can apply online by using Health-e-Arizona Plus at www.healthearizonaplus.gov

Keep Pages A, B, C, D, E, F, and G for your records

If you are over age 65, blind or disabled, or if you are eligible for Medicare, use this application to apply for AHCCCS Medical Assistance and/or Medicare Savings Programs. Or, you can apply online at www.healthearizonaplus.gov.

How can I qualify for AHCCCS Medical Assistance?

- Your gross monthly income can be no more than $1,133 for an individual or $1,526 for a couple (after a $20 standard deduction and other allowed deductions if you have earned income and/or dependent children).
- You must be a resident of the state of Arizona and a United States citizen or a non-citizen who meets Medicaid requirements.
- You must apply for pension, disability or retirement benefits if potentially available to you.
- If you are under age 65 and not receiving Social Security Disability income, a disability determination will be part of your application process.

How can I qualify for a Medicare Savings Program?

If you are receiving or eligible for Medicare Part A, use this application to apply for help with your Medicare premium(s), copayments and deductibles. There are three Medicare Savings Programs. Each one has a different income limit and different benefits.

Medicare Savings Program	**Qualified Medicare Beneficiary (QMB)**		**Specified Low-Income Beneficiary (SLMB)**		**Qualified Individual – 1 (QI-1)**	
General Eligibility Requirements:	•You must be a resident of the state of Arizona. •You must be a United States citizen or a non-citizen who meets Medicaid requirements. •You must apply for pension, disability or retirement benefits if potentially available to you.					
Monthly Income Limits (after allowed deductions):	Individual	Couple	Individual	Couple	Individual	Couple
	$0 - $1,133	$0 - $1,526	$1,133.01 - $1,359	$1,526.01 - $1,831	$1,359.01 - $1,529	$1,831.01 - $2,060
Specific Requirements:	Receiving or eligible for Medicare Part A		Receiving Medicare Part A		Receiving Medicare Part A	
What is the Benefit?	• Pays your Medicare Part B Premium • Pays your Medicare Part A Premium (if not free) • Pays your Medicare coinsurance • Pays your Medicare Deductibles*		• Pays your Medicare Part B Premium		• Pays your Medicare Part B Premium	

*If you are enrolled with a Medicare HMO, your co-pays will also be paid. If you elect additional coverage from a Medicare HMO, you will be responsible for any additional premiums and costs.

What services does AHCCCS Medical Assistance cover?

- Prescription medication*
- Doctor's office visits
- Hospital services
- Dialysis
- 90 days of nursing care services
- Medical supplies
- Chemotherapy
- Behavioral health care
- Immunizations (shots)
- Emergency medical care
- Medically necessary transportation
- Medically necessary specialist care
- Laboratory and X-ray services
- Rehabilitation services
- Chiropractic services

*AHCCCS prescription coverage is limited for people who have Medicare.

What does AHCCCS Medical Assistance cost?

Premiums

Most people do not have to pay a monthly premium for AHCCCS Medical Assistance. Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the monthly premium amounts are:

- $10 - $70 for KidsCare
- $10 - $35 per person for employed people with disabilities

American Indians and Alaskan Natives: Per federal law, American Indians enrolled with a federally recognized tribe, children and grandchildren of American Indians enrolled with a federally recognized tribe and certain Alaskan Natives do not have to pay a premium. To get AHCCCS Medical Assistance at no cost, you must give us proof of tribal enrollment.

Co-payments

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- $2.30 to $10.00 for prescriptions
- $0 to $30.00 for non-emergency use of an emergency room
- $2.30 to $3.00 for physical, occupational or speech therapy
- $3.40 to $5.00 for outpatient visits for evaluation and management services including doctor's office visits

Remember to report any changes in income because this may change your co-payment amount.

The following people are never asked to pay co-payments:

- Children under age 19.
- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services (CRS) program.
- People who receive hospice care.
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services.
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638 or urban Indian health programs.
- People who are acute care members and who are residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days per contract year.

In addition, co-payments are never charged for the following services for anyone:

- Hospitalizations
- Emergency services
- Family planning services and supplies
- Services paid for on a fee-for-service basis
- Pregnancy-related health care including tobacco cessation treatment for pregnant women

How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS Complete Care (ACC) plan unless:

- You are American Indian and you choose American Indian Health Program as your health plan.
- You are approved for one of the Medicare Savings Programs.
- AHCCCS can only pay for your emergency services because of your status with United States Citizenship and Immigration Services. If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

How does a health plan work?

- The health plan works with health care providers (doctors, hospitals, pharmacies, etc.) to provide all AHCCCS covered services.
- The health plan will send you a member handbook once you are enrolled.
- You can call the health plan if you have any questions about your benefits or services or if you need an accommodation because of a disability or interpreter services. The phone number for your health plan's member or customer services can be found on your AHCCCS ID Card and in your Member Handbook.

How can I get behavioral health services?

- You can go through your primary doctor, or
- Call the behavioral health telephone number on your AHCCCS ID Card.

What if I have Medicare or other health insurance?

- Be sure to tell your health plan that you have Medicare or any other health insurance.
- If your doctor does not contract with your AHCCCS Complete Care (ACC) plan, your doctor must call the ACC plan to coordinate care or you may be responsible for any Medicare or other health insurance co-payments or deductibles.
- If you are in an HMO, you should pick a primary doctor who works with both your HMO and your ACC plan.
- If you have Medicare, your prescription coverage under AHCCCS is limited. If you have questions about prescriptions, call 1-800-MEDICARE (633-4227), or your AACC plan.

What do primary doctors and specialists do?

Once enrolled, you will get a list of primary doctors in your area from the health plan. You must choose your primary doctor or one will be assigned to you. You have the right to change your primary doctor at any time by calling your health plan's member or customer services. Your primary doctor will:

- Take care of your health care.
- Be responsible for authorizing your non-emergency medical services.
- Be the first person you go to for non-emergency medical care.
- Send you to a specialist when needed.

Who Can Complete an Application?

This application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your family members. The terms “applicant” and “you” on this form refer to the person applying for AHCCCS Medical Assistance and/or Medicare Savings Program benefits. **You and your spouse can use the same application form to apply**. If you have a conservator or guardian, your conservator or guardian must complete this form for you.

Instructions to the Applicants

Check **Yes** or **No** on the application form when asked if you are applying for AHCCCS Medical Assistance or for help to pay Medicare costs. You can check **Yes** to either question or to both.

- Answer all questions on pages 1 through 6 for each person applying.
- If you need more room, attach additional sheets of paper to provide all requested details.
- Read page E for an explanation of your rights and responsibilities and providing a social security number.
- Sign the application.
- Attach all requested verification when you send your application.
- Keep pages A, B, C, D, E, F, and G for your records and mail pages 1 through 6 to the MA-SP Office:

AHCCCS Medical Assistance
Specialty Programs (MA-SP)
801 E Jefferson St
Phoenix AZ 85034
FAX: 602-258-4619

- If you are applying for AHCCCS Medical Assistance, read page G and choose an AHCCCS Complete Care (ACC) plan.
- If you have any questions regarding these programs, or need help filling out the application, please call:
  - If you are calling from area codes (480, 602 or 623) dial (602) 417-5010 and choose option 5.
  - If calling from area codes (520, 760 or 928) dial toll free 1-800-528-0142.

After we receive your application, we will either contact you for additional information or, if your application is complete, make a decision about whether you qualify. We will send you a notice explaining the decision.

RIGHTS AND RESPONSIBILITIES OF APPLICANTS/RECIPIENTS

You have the **RIGHT** to:

1. Be treated fairly and equally regardless of race, religion, national origin, sex, age, disability, or political beliefs.
2. To apply for AHCCCS Medical Benefits and to be given a notice that tells you if you are eligible or not.
3. Review AHCCCS manuals that show the rules and regulations of the AHCCCS program if you want to know the reason why your application is denied.
4. Have all information you give regarding your eligibility kept private according to state and federal law.
5. A fair hearing if you disagree with an adverse action taken by the AHCCCS Administration. Adverse action means your application for AHCCCS services was denied, your AHCCCS benefits were ended or your AHCCCS services were reduced. You may also request a hearing if a decision is not made on your application within 45 days and the delay is due to AHCCCS. Your hearing will be conducted by an Administrative Law Judge and a decision will be issued by the AHCCCS Director. You have the right to review your case record before the hearing. You have the right to represent yourself or to have someone else represent you. If you wish to ask for a hearing, your request must be in writing and mailed or delivered to the Office of the General Counsel, 801 East Jefferson St., PO Box 25520, MD 6200, Phoenix, Arizona 85034 or faxed to 602-253-9115.

You have the **RESPONSIBILITY** to:

1. Provide AHCCCS with the needed information to correctly determine your eligibility and authorize AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information which pertains to eligibility.
2. Take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to Social Security benefits, Railroad Retirement, Veterans benefits and unemployment compensation.
3. To report payments going in or out of your trust, if you have one.

If you are eligible you **MUST**:

1. Notify the AHCCCS/ALTCS office as soon as possible but no later than within 10 days by phone, letter or in person, whenever there are any changes in your income, address, marital status, Medicare coverage, household composition, or other circumstances which could affect your eligibility.
2. Cooperate with Arizona or Federal personnel in the completion of a quality control review of your eligibility.

PROVIDING SOCIAL SECURITY NUMBERS and IMMIGRATION STATUS

You must provide or apply for a Social Security number (SSN) for every applicant. Immigrants who are not legally able to obtain a SSN are not required to provide one. This is required under the Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369. Providing a Social Security number for someone who is not applying is optional. We will not use your SSN as your AHCCCS identification number. Your SSN will be used to check the identity of those receiving assistance, to prevent double payments, to determine benefits available under other programs, to verify state residency or other conditions of eligibility, and to make mass annual changes more easily. Your SSN will be used in computer matching available through the State Income and Eligibility Verification System (IEVS) to obtain wage, income and other information from: (a) the IRS, (b) the Social Security Administration, (c) Arizona Department of Economic Security, and (d) other states administering TANF, Medicaid, Unemployment Insurance, Food Stamps, Programs under Title I, X, XIV, XVI of the SSA and other state wage information collection agencies. AHCCCS will use the

information available from this computer matching to verify income and whether you have Medicare. When the information you give is questionable, AHCCCS will verify the information by contacting other sources.

ASSIGNMENT OF RIGHTS TO OTHER BENEFITS FOR MEDICAL CARE

(Applicable only to AHCCCS Medical Assistance and the Qualified Medicare Beneficiary Program)

I understand that if I am or members of my family are approved for AHCCCS benefits, AHCCCS can collect payment from any other parties who may be responsible for paying for our health care costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that AHCCCS cannot collect more than the costs paid by AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

How to choose a health plan

You need to choose an AHCCCS Complete Care (ACC) health plan that serves your county.

- All ACC plans provide the same covered medical services.
- Before choosing an ACC plan, check with your doctor, pharmacy or hospital to see if they work with the ACC plan that you want. If you want more information about the doctors, specialists or hospitals that work with an ACC plan that serves your county, call the number listed below for the ACC plan or visit the ACC plan's website.
- American Indian members may choose from American Indian Health Program or an ACC plan.
- If you do not choose an ACC plan, one will be assigned to you.
- If you have been enrolled in an ACC plan within the past 90 days, you may be enrolled with your previous ACC plan.
- If you need help selecting an ACC plan you may speak to a Benefits and Eligibility Specialists by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800)-334-5283 from area codes (520) and (928).

Geographic Service Area (GSA)	Available AHCCCS Complete Care (ACC) Health Plans
North • Apache • Coconino • Mohave • Navajo • Yavapai	• American Indian Health Program • Care1st Health Plan • Health Choice Arizona
Central • Maricopa • Gila • Pinal, excluding ZIP codes 85542, 85192, and 85550	• American Indian Health Program • Arizona Complete Health - Complete Care Plan (formerly Health Net Access) • Banner-University Family Care • Molina Complete Care • Mercy Care • Health Choice Arizona • UnitedHealthcare Community Plan
South • Cochise • Graham • Greenlee • La Paz • Pima • Santa Cruz • Yuma • ZIP codes 85542, 85192, and 85550	• American Indian Health Program • Arizona Complete Health - Complete Care Plan (formerly Health Net Access) • Banner-University Family Care • UnitedHealthcare Community Plan (Pima County Only)

Health Plan Name	Phone Number	Website
American Indian Health Program	Maricopa County: 602-417-7100 All other counties: 1-800-334-5283	www.azahcccs.gov/AmericanIndians/AIHP/
Arizona Complete Health - Complete Care Plan (formerly Health Net Access)	1-888-788-4408	www.azcompletehealth.com/completecare
Banner-University Family Care	1-800-582-8686	www.bannerufc.com/acc
Care1st Health Plan	1-866-560-4042	www.care1staz.com
Molina Complete Care	1-800-424-5891	www.mccofaz.com
Mercy Care	1-800-624-3879	www.mercycareaz.org
Health Choice Arizona	1-800-322-8670	www.healthchoiceaz.com
UnitedHealthcare Community Plan	1-800-348-4058	www.uhccommunityplan.com

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Application Form

Are you applying for AHCCCS Health Insurance? ☐Yes ☐No
Are you applying for help to pay Medicare costs? ☐Yes ☐No

APPLICANT INFORMATION

First Name:	MI:	Last Name:	Social Security Number:

Date of Birth:	☐Male ☐Female	Medicare Claim Number:

Are you a U.S. Citizen?

☐Yes, a U.S. citizen
☐No, not a U.S. citizen

If no, what number is on your immigration card?

A_____

What is your immigration status?

☐Lawful Permanent Resident (LPR)
☐Asylee
☐Refugee
☐American Indian Born in Canada
☐Cuban-Haitian Entrant
☐Hmong or Laotian Highlander
☐Victim of Trafficking
☐Afghan/Iraqi Special Immigrant
☐Battered Alien
☐Conditional Entrant
☐Deportation Withheld
☐Indefinite Detainee
☐Parolee for at Least One Year
☐Citizen of Republic of the Marshall Islands
☐Citizen of Federated States of Micronesia
☐Citizen of Republic of Palau
☐Other: _____

Home Address:	City:	State:	ZIP Code:

Mailing Address (if different):	City:	State:	ZIP Code:

Home Phone Number:	Work Phone Number:	Message Number:	E-mail Address:

What language do you speak? ☐English ☐Spanish ☐Other _____
What language do you read? ☐English ☐Spanish ☐Other _____

Ethnic Group - Optional (will not affect eligibility) ☐Hispanic ☐Non-Hispanic Latino

Race (Select one or more) (Optional) ☐White ☐Asian ☐Native American
☐Black/African American ☐Hawaiian or other Pacific Islander ☐Alaska Native

Check your current Marital Status:
☐Never Married ☐Married ☐Divorced
☐Common-Law ☐Widowed

Effective Date of Current Marital Status:

If married, do you and your spouse live together? ☐Yes ☐No

If No, date of separation: _____

Did anyone you are applying for receive medical services in the last three months and need help with these expenses? ☐Yes ☐No If so, who? _____

What months? _____ _____ _____

Is the person needing help with medical expenses pregnant or had a pregnancy end in the last 5 months?

☐Yes ☐No

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:
☐Letters in HEAplus account (note: this person must have an HEAplus account)
☐Readable PDF sent by secure email
☐Large print: larger print letters sent by U.S. mail will be provided Arial 24-point font.
☐Other: _____

Authorized Representative

If you want to allow someone else to represent you or you have a legal guardian, provide the information below.

Representative's Name: _____
Is the representative acting on behalf of an organization? ☐Yes ☐No
Organization's Name: _____
Is the representative your legal guardian? ☐Yes ☐No
Representative's Date of Birth (optional):_____
Representative's Mailing Address: _____
City:_____ State: _____ ZIP Code: _____
Representative's Phone Number: _____
What is the representative's preferred language to speak?
☐English ☐Spanish ☐Other: _____
What is the representative's preferred language to read?
☐English ☐Spanish ☐Other: _____

My representative would like to get information about this application by:
E-mail: ☐Yes ☐No E-mail address: _____
Text: ☐Yes ☐No Number to text (standard text rates apply): _____
If 'Yes' is not marked for E-mail or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

By signing below, I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore: • Give permission for my representative to complete and sign my application. • Give permission for my representative to provide any documents requested, including personal information. • Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled. • Agree to give information about my personal circumstances to my representative. • Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.	By signing below, I, the representative, agree to act on the customer's behalf. I also agree to: • Maintain the confidentiality of any information regarding the applicant or beneficiary provided by the agency. • Provide only truthful and complete information under penalty of perjury. • Fill in and sign needed forms. • Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer's Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer's spouse, minor children, and parents (if the customer is a minor child). • Tell DES and/or AHCCCS right away if the customer: • Has an increase or decrease in income; • Has an increase or decrease in assets; • Changes ownership of assets, including opening or closing financial accounts; • Has a change in address; or • Has a change in health insurance or the amount of premiums paid.
If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.	

PRINTED NAME OF CUSTOMER	PRINTED NAME OF REPRESENTATIVE
SIGNATURE OF CUSTOMER DATE	SIGNATURE OF REPRESENTATIVE DATE
PRINTED NAME OF WITNESS (IF CUSTOMER SIGNED WITH A MARK)	PRINTED NAME OF REPRESENTATIVE ORGANIZATION (WHEN APPLICABLE)

SPOUSE'S INFORMATION, If living together

Spouse's First and Last Name:	Spouse's Date of Birth:	Spouse's Social Security Number (optional if not applying):

Is your spouse applying for AHCCCS Medical Assistance? ☐Yes ☐No
Is your spouse applying for help to pay Medicare Costs? ☐Yes ☐No
Does your spouse need help paying for medical bills from the last three months? ☐Yes ☐No
What months? _____ _____ _____

If applying, Spouse's Medicare Claim Number: _____

If applying, Ethnic Group of Spouse (Optional): ☐Hispanic ☐Non-Hispanic Latino

If applying, Race of Spouse (Select one or more) (Optional)
☐White ☐Asian ☐Native American ☐Black/ African American
☐Alaska Native ☐Hawaiian or other Pacific Islander

If applying, is your spouse a U.S. Citizen?

☐Yes, a U.S. citizen
☐No, not a U.S. citizen

If no, what number is on your immigration card?
A_____

What is your spouse's immigration status?

☐Lawful Permanent Resident (LPR)

☐Asylee
☐Refugee
☐American Indian Born in Canada
☐Cuban-Haitian Entrant
☐Hmong or Laotian Highlander
☐Victim of Trafficking
☐Afghan/Iraqi Special Immigrant
☐Battered Alien
☐Conditional Entrant
☐Deportation Withheld
☐Indefinite Detainee
☐Parolee for at Least One Year
☐Citizen of Republic of the Marshall Islands
☐Citizen of Federated States of Micronesia
☐Citizen of Republic of Palau
☐Other: _____

DEPENDENT CHILDREN INFORMATION

Do you have any unmarried children living with you who are under age 18 or under age 22 and a student? ☐Yes ☐No

If YES, list below. If you need more space, attach a separate piece of paper with the information requested.

Child's Full Name (Last, First)	Child's Date of Birth	Child's Social Security Number (optional)	Type of School, if Student

NON-FINANCIAL INFORMATION	Applicant	Spouse (if applying)
1. Do you live in Arizona?	☐Yes ☐No	☐Yes ☐No
2. Do you receive Medicare Part A?	☐Yes ☐No	☐Yes ☐No
3. Do you receive Medicare Part B?	☐Yes ☐No	☐Yes ☐No
4. Have you been determined blind or disabled by the Social Security	☐Yes ☐No	☐Yes ☐No
5. If you answered NO to number 4 and you are under age 65, do you have a disability that has kept or will keep you from working for at least 12 months?	☐Yes ☐No	☐Yes ☐No
6. Are you a person under age 65 who has lost Title II Social Security Disability benefits because of earnings?	☐Yes ☐No	☐Yes ☐No

INCOME

Do you, your spouse, or your dependent children receive or expect to receive any of the following types of income? Check Yes or No for each item.

☐Yes	☐No	Employment Income	☐Yes	☐No	Veteran's Benefits	☐Yes	☐No	Rental Income
☐Yes	☐No	Self Employment Income	☐Yes	☐No	Annuity Income	☐Yes	☐No	Mortgage/ Contract Payments
☐Yes	☐No	Social Security Benefits	☐Yes	☐No	Winnings (Lottery/Gambling)	☐Yes	☐No	Child Support/ Alimony
☐Yes	☐No	Interest on financial accounts	☐Yes	☐No	Gifts/loans/ contributions	☐Yes	☐No	BIA/Tribal Assistance
☐Yes	☐No	Royalties/Dividends	☐Yes	☐No	Disability Insurance	☐Yes	☐No	Payments from a trust
☐Yes	☐No	Cash Assistance	☐Yes	☐No	Unemployment Insurance	☐Yes	☐No	Tips or Commissions
☐Yes	☐No	Pensions	☐Yes	☐No	Student Grants/ Scholarships/Loans	☐Yes	☐No	Earned Income Tax Credit (EITC)
☐Yes	☐No	Railroad Retirement	☐Yes	☐No	Payments for Room/Board	☐Yes	☐No	Other:_____

For each item marked YES, provide all of the information requested below. If you need more room, attach a separate piece of paper containing the requested information. SEND CURRENT VERIFICATION OF ALL INCOME LISTED (FOR EXAMPLE, CHECK STUBS, AWARD LETTERS, THE MOST RECENT INCOME TAX FORMS, IF SELF EMPLOYED). COPIES ARE ACCEPTABLE.

Name of Person Receiving the Income	Type of Income	Date received or expected to be received	Gross Amount (before deductions)	How often received? (weekly, bi-weekly, etc.)

Has there been a change in any of your income during the last three months or do you expect a change in income? If Yes, complete below. If you need more room, attach a separate piece of paper with the information requested.	☐Yes ☐No

Date of change or expected change:	Type of income affected:	What is the change?

POTENTIAL BENEFITS

Are you or your spouse a veteran?	☐Yes ☐No
Are you the widow/widower of a veteran?	☐Yes ☐No
Have you, your spouse or your deceased spouse ever worked for a government agency, or employer with a disability or pension plan?	☐Yes ☐No

If you answered YES to any of these questions, provide the following information about the veteran or employee:

Name:	Military ID Number:	Date of Birth:	Date of Death:
Dates of employment and/or Military service:		Employer's address:	
Employer/Branch of Service:			

MEDICAL COVERAGE

Do you or your spouse have medical insurance coverage, other than Medicare? If Yes, complete the information below and SEND A COPY OF THE INSURANCE ID CARD.	☐Yes ☐No

Name of Insurance Company	Who is covered by Insurance?

Do you or your spouse have an injury or illness resulting from an accident (pedestrian automobile, or other vehicle, on the job, etc.)? If Yes, complete the items below:	☐Yes ☐No

Name	Type of Injury	Date of Injury	Name and Address of Insurance or Company Responsible for Medical Costs due to the Injury

If eligible for AHCCCS Medical Assistance or QMB, by signing this application, I agree to assign to AHCCCS all rights to third party payments of medical expenses, including insurance coverage, to the extent that costs are paid by AHCCCS.

HEALTH PLAN CHOICE

If you are applying for AHCCCS Medical Assistance, choose an AHCCCS Complete Care (ACC) plan that serves your county. See page G or a list of health plans.

Name of AHCCCS Complete Care (ACC) plan you choose (from page G):

YOUR OPPORTUNITY TO REGISTER TO VOTE

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

☐Yes ☐No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the State Election Director, Secretary of State's Office, 1700 West Washington, Phoenix, AZ 85007, 602-542-8683.

You may also get a voter registration form at https://azsos.gov/elections

PENALTY WARNING

The information provided on this form may be verified by federal, state, and local officials. If anything is inaccurate, you may be denied benefits.

1. You must not knowingly withhold or give false information with the intent to receive or to continue receiving AHCCCS benefits to which you are not entitled.
2. You will be required to pay back to AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.

It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

RELEASE OF INFORMATION

I authorize AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility.

STATEMENT OF TRUTH

I swear or affirm under penalty of perjury that the oral or written statements made regarding the persons in my home, my income, and any other items that pertain to my possible eligibility for AHCCCS Medical Assistance or Medicare Savings Program benefits are true and correct to the best of my knowledge and that any photocopies I have provided are the same as the original. I have read and understand the penalty warning. I have read and understand my rights and responsibilities, and providing Social Security numbers on page E of this application. I further agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits. I certify that the citizenship/immigration status is correct for each person applying. I do not have to give information on citizenship or immigration status of family members who are not applying for healthcare benefits. I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF WITNESS (if applicant signed with a mark)	DATE
SIGNATURE OF SPOUSE	DATE	SIGNATURE OF REPRESENTATIVE	DATE

NOTICE OF NON-DISCRIMINATION

The Arizona Health Care Cost Containment System (AHCCCS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AHCCCS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AHCCCS provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats). AHCCCS provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Health-e-Arizona Plus Customer Support Center at 1-855-432-7587 (TTY: 711).

If you believe that AHCCCS failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the AHCCCS General Counsel. You can file a grievance in person or by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination. Submit your grievance to: General Counsel, AHCCCS Administration, Office of the General Counsel, MD 6200, 801 E. Jefferson St, PO Box 25520, Phoenix, AZ 85034. Phone: 602-417-4455, fax: 602-253-9115. Email: EqualAccess@azahcccs.gov. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

AVISO DE NO DISCRIMINACIÓN

Arizona Health Care Cost Containment System (AHCCCS) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. AHCCCS no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo. AHCCCS proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes intérpretes de lenguaje de señas capacitados y información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, y otros formatos). AHCCCS proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes intérpretes capacitados y información escrita en otros idiomas. Si necesita recibir estos servicios, comuníquese con Health-e-Arizona Plus Customer Support Center at 1-855-432-7587 (TTY: 711).

Si considera que AHCCCS no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a AHCCCS General Counsel. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Su querella deberá presentarse por escrito en plazo de 180 días a partir de la fecha en la que la persona que se querelle se percate de lo que le parezca ser discrimen. Remita su querella a: General Counsel, AHCCCS Administration, Office of the General Counsel , MD 6200, 801 E. Jefferson St., PO Box 25520, Phoenix, AZ 85034. Número de teléfono 602-417-4455, o envíela por fax a: 602 253 9115 0 envíela por correo electrónico (E-mail) a: EqualAccess@azahcccs.gov. También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación: U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building;Washington, D.C. 20201;1-800-368-1019, 800-537-7697 (TDD). Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

English	If you speak English, language assistance services, free of charge, are available to you. Call 1-855-432-7587 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-432-7587 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló̜, koj̨į' hódíílnih 1-855-432-7587（TTY: 711）
Apache	Ndéé k'ehgo yánłt'i'yúgo Ndéé biyát'į'híí bee kich'į' ódiihíí beegozáá áłdó' do hát'íí ileegoda. Náh inlk'id ánt'iiyúgo béésh bich'i' nłltsogyúgo díí bik'ehgo bil ónlchííd 1-855-432-7587 (TTY: 711)
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-432-7587（TTY：711）
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-432-7587 (TTY:711).
Arabic	ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-7587-432-885 (رقم هاتف الصم والبكم:711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-432-7587 (TTY:711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-432-7587 (TTY: 711) 번으로 전화해 주십시오.
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-432-7587 (ATS : 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-432-7587 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-432-7587 (телетайп: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-432-7587（TTY: 711）まで、お電話にてご連絡ください
Serbo-Croatian/ Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-432-7587 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Syriac/ Assyrian	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܫܩܠܝܬܘܢ ܚܠܦܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-855-432-7587 (TTY: 711)).
Persian/ Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY:711) 1-855-432-7587 تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-432-7587 (TTY:711).