APPLICATION FOR ARIZONA LONG TERM CARE SYSTEM (ALTCS)

ALTCS.ORG USE ONLY

Customer Name: _____

Person: _____

AHCCCS ID: _____

Companion Case ☐ Yes ☐ No

Date recieved: 04/16/2021

Community Spouse ☐ Yes ☐ No

1. Name of Applicant (print - Last, First, Middle Initial):

2. Other Names Used (Maiden, Former, Alias)

3. Social Security Number:

4.a. Birth date:

4.b. Birthplace (City, State, Country):

5. U.S Citizen ☐ Yes ☐ No

(If NO complete #16)

6. Marital Status

	7. Date:
☐ Married	
☐ Never married	
☐ Divorced	
☐ Separated	
☐ Separated due to Institutionalization	
☐ Common Law	
☐ Widowed	

8. Ethnic Group - You do not have to answer this (will not affect eligibility

☐ White ☐ Asian/Pacific Islander

☐ Hispanic ☐ Cuban/Haitian

☐ Black ☐ Other _____

☐ American Indian

9. Complete the following if someone other than the applicant is filing the application

Name (Last, First, MI):	Title/Relationship to Applicant:	Phone No:	Message Phone No:

Street Address:	City:	State:	Zip Code:

10. Does the applicant have a Conservator, Guardian or legal representative? ☐ YES ☐ NO If YES, list below:

Name of Conservator/Guardian:	Relationship to Applicant:

Mailing Address (Street, City, State, Zip):	Phone No:

11. If the applicant is a child under 19 year's old, complete the following:

Mother's Information

Mother's Name:	Check any box that applies: ☐ Deceased ☐ Absent ☐ Incapacitated ☐ Unemployed

Mother's Address (Street, City, State, Zip):	Birthdate:

Phone No:	Social Security No:

Father's Information

Father's Name:	Check any box that applies: ☐ Deceased ☐ Absent ☐ Incapacitated ☐ Unemployed

Father's Address (Street, City, State, Zip):	Birthdate:

Phone No.	Social Security No.

AGENCY USE ONLY:

12. Check the box which describes your current living arrangement.

☐ Live at home

☐ Live in a nursing home

1. Date entered: _____
2. Date expected to return home: _____

Do you live in the same nursing home as your husband or wife? ☐YES ☐NO

☐ Inpatient in a hospital

1 Date entered _____

2. Date expected to return home or move to a nursing home?

_____

☐ Live at home and receive one or more in-home services (meals-on-wheels, visiting nurse, housekeeping services, etc.).

Date began receiving in-home care _____

☐ Other: explain _____

☐ Applicant Deceased: _____

13. A. If you reside in a hospital or nursing facility, what country and state were you living in prior to entering the facility?

_____

B. Do you consider yourself a resident of that county? ☐YES ☐NO
If NO, explain: _____

C. Dale entered present county: _____

D. Did you live on an Indian Reservation immediately before you entered the nursing home? ☐YES ☐NO
If YES, complete the items below: _____

Name of Reservation	Country in Which you Lived

14. If you are applying for ALTCS and are legally married to a spouse who resides in the community have you ever:

A .Been admitted to a hospital since September 30, 1989? ☐YES ☐NO

B. Been admitted to a nursing facility since September 30, 1989? ☐ YES ☐ NO

C. Received any in-home services (e.g. home delivered meals, home health aide, adult day health, therapy, etc.) since September 30, 1989? ☐YES ☐NO

D. Lived in a residential facility (e.g. Adult Foster Care Home, Assisted Living Home, Assisted Living Center-Unit, Behavioral Health Center, etc.) since September 30, 1989? ☐YES ☐NO

If yes to any of the above questions, please explain:

_____

15. Complete the following if you are living apart from your spouse:

Reason no longer living with spouse:		Date last lived together:
Name of Spouse (Last, First, MI):	Street Address of Spouse (City, State, Zip):	
Mailing Address of Spouse, if different:	Spouse's SSN:	Spouse's Phone No.

16. Are you a non-citizen who is presently in the U.S. with the knowledge and permission of the U.S. Citizenship and immigration services (USCUS)? ☐YES ☐NO If Yes complete below.

Name of Alien/Refugee:	Date Entered U.S.	Alien Registration Number

17. Do you live in Arizona and intend to remain in Arizona? ☐YES ☐NO If NO, complete the items below:

Date left Arizona or Date Intending to Leave Arizona:	Date Expected to Return:

AGENCY USE ONLY

18. For questions 18 through 32, please answer each question as it applies to the following people: You, your spouse if you are married, your parents if you are under age 18, your own children under age 18.
You do not have to provide information about your adult children or anyone else who may be living with you.
NOTE: Birthdates and Social Security Numbers are optional.

A	Name (Last, First, Middle Initial):	Other Names Used:		Relationship to Applicant:	
	Social Security Number:	Birthdate:	Sex ☐ M ☐ F	☐ Blind ☐ N/A ☐ Disabled	Student ☐ Yes ☐ No
B	Name (Last, First, Middle Initial):	Other Names Used:		Relationship to Applicant:	
	Social Security Number:	Birthdate:	Sex ☐ M ☐ F	☐ Blind ☐ N/A ☐ Disabled	Student ☐ Yes ☐ No
C	Name (Last, First, Middle Initial):	Other Names Used:		Relationship to Applicant:	
	Social Security Number:	Birthdate:	Sex ☐ M ☐ F	☐ Blind ☐ N/A ☐ Disabled	Student ☐ Yes ☐ No
D	Name (Last, First, Middle Initial):	Other Names Used:		Relationship to Applicant:	
	Social Security Number:	Birthdate:	Sex ☐ M ☐ F	☐ Blind ☐ N/A ☐ Disabled	Student ☐ Yes ☐ No

RESOURCES

19. Do you or anyone listed in Section 18 (above) in your household own, singly or jointly with anyone else, any of the following? You should answer "yes' if you are listed as the owner even if you do not consider the resource as belonging to you. You must also list all resources that are held for you by another person. Be sure to list items you own out of state. Check "YES or NO for each item.

	Yes	No		Yes	No
Cash on Hand	☐	☐	Notes or Contracts (including Deeds of Trust)	☐	☐
Checking Accounts	☐	☐	Mutual Fund Shares	☐	☐
Savings Accounts	☐	☐	Investment Accounts	☐	☐
Stocks or Bonds	☐	☐	Inheritances	☐	☐
Patients Trust or Nursing Home Account	☐	☐	Promissory Notes	☐	☐
Time Deposits (CD's)	☐	☐	Loan Agreements	☐	☐
Credit Union Accounts	☐	☐	Property Agreements	☐	☐
Money in another person' s account	☐	☐	Life Insurance(s) (List all policies below)	☐	☐
IRA/Keough	☐	☐	Burial Insurance	☐	☐
Trust or Trust Funds	☐	☐	Burial Fund	☐	☐
Stocks or Bonds (Savings/Other)	☐	☐	Burial Plan	☐	☐
Retirement Accounts	☐	☐	Life Insurance Funded Burial Plan	☐	☐
Indian Claims	☐	☐	Other	☐	☐
Money Market Account	☐	☐			

Item	In Whose Name(s)	Name and Address of Bank/Institution/Company	Account/Policy Numbers	Claimed Amount

VEHICLES

20. Do you or anyone listed in Section 18 (page 3) own, singly or jointly with anyone else, any of the following vehicles? You should answer "yes" if you are listed as the owner even if you do not consider the resource as belonging to you. You must also list all resources that are held for you by another person. Be sure to list any items you own out-of-state. Check YES or NO for each item.

	Yes	No		Yes	No		Yes	No
Automobile	☐	☐	Boat	☐	☐	Recreational Vehicle	☐	☐
Truck/Van	☐	☐	Motorcycle	☐	☐	Off-Road Vehicle	☐	☐
Camper/Golf Cart	☐	☐	Airplane	☐	☐	Other (specify)	☐	☐

If YES to an of the above, complete the items below:

Type, Make Model & Year	In Whose Name(s)	Current Value	Amount Owed	USED FOR: Employment Yes	Employment No	Medical Treatment Yes	Medical Treatment No	Daily Activity Yes	Daily Activity No
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

Complete the following information on each of the vehicles listed above:

Type, Make, Model & Year	Specifically Equipped for an Individual with a Disabilit Yes	Specifically Equipped for an Individual with a Disabilit No	In Running Condition Yes	In Running Condition No	Number of Cylinders	Mileage	Optional Equipment (Air Conditioning, Power Steering, Stereo. Etc.)
	☐	☐	☐	☐			
	☐	☐	☐	☐			
	☐	☐	☐	☐			

21A. Do you or anyone listed in Section 18 (page 3) own, singly or jointly with anyone else, any of the following? You should check "yes" if you are listed as the owner even if you do not consider the resource as belonging to you. You must also list all resources that are held for you by another person. Check YES or NO for each item. Be sure to list any items you own out-of-state.

	Yes	No		Yes	No
The House, Trailer or Mobile Home you live in	☐	☐	Life Estate	☐	☐
Other House, Land, Buildings	☐	☐	Livestock	☐	☐
Other Trailer, Mobile Home	☐	☐	Grazing Permits	☐	☐
Burial Plots	☐	☐	Other _____	☐	☐
Vacation Property	☐	☐			

If YES, complete all of the columns about each item.

Type	Person(s) listed as owners	Address/Description	CMV	Owed

21 B. Is any of the property listed above co-owned with any other person? ☐Yes ☐No

If YES, which property? _____

AGENCY USE ONLY

22. Have you or your spouse sold, traded, transferred or given away money, vehicles, property or other personal resources since July 1, 2006? ☐ Yes ☐ No If YES. complete the items below:

Items Sold, Traded or Given Away	Person Who Sold, Traded or Gave Away Item	Date	To Whom	At Time of Transfer		Amount Rec'd or Value of Item Rec'd in Trade
				Marke Value	Amount Owed	

Reason for sale or transfer:

23. Have you or your spouse ever placed items into a trust in the last 60 months?
☐YES ☐NO If YES, complete the items below:

Items Placed in Trust	Person Making Placement	Date	Name of Trust	Value of Item at Time of Placement	Amount Owed on Item at Time of Placement

UNEARNED INCOME

24A. Do you or anyone listed in Section 18 (page 3) receive or expect to receive any of the following types of income? Check YES or NO for each item. If YES, explain below:

	Yes	No
Social Security Benefits	☐	☐
Supplemental Security (SSI)	☐	☐
Public Assistance (TANF, GA, Food Stamps, SPP, etc.)	☐	☐
BIA/Tribal Assistance	☐	☐
Energy Assistance	☐	☐
Unemployment Insurance	☐	☐
Disability Insurance	☐	☐
Veteran's Benefits/Military Allowances	☐	☐
Railroad Retirement/Other Retirement or Disability Pensions	☐	☐
Gifts/Loans/Contributions from Friends or Relatives	☐	☐
Child Support/Alimony	☐	☐
Student Grants/Scholarships/Loans	☐	☐
Winnings (Lottery. Bingo, Gambling)	☐	☐
Foster Care Payments	☐	☐

	Yes	No
Vocational Rehabilitation	☐	☐
Life Insurance Proceeds	☐	☐
Job Training Partnership Act (JTPA)	☐	☐
Rental Income	☐	☐
Income from Roomers/Boarders	☐	☐
Mortgage/Sales Contract Income	☐	☐
Indian Claims/Payments	☐	☐
Annuities	☐	☐
Land Lease	☐	☐
Industrial/Worker's Compensation	☐	☐
Strike Pay	☐	☐
Other, specify: _____	☐	☐
Other, specify: _____	☐	☐
Other, specify: _____	☐	☐

If YES, complete the items below:

Name of Person Receiving Income	Type of Income	Date Received or Expected	Gross Amount	How Often Received

24B. Will any of the amounts you receive ever change, such as due to a cost of living increase? ☐ YES ☐ NO
If YES, please give the date and explain the reason for the change:

24C. Do you or anyone listed in Section 18 (page 3) have any expenses (such as lawyer's fees, etc.) in obtaining any of the income listed in uestions #24A above? ☐ YES ☐ NO If YES, complete all the columns below about the item.

Name of Person	Type of Income	Type of Expense	Date Paid	Amount Paid

EARNED INCOME

25. Do you or anyone listed in Section 18 (page 3) receive or expect to receive any money this month or next month from any of the following sources: earnings, commissions, tips, Earned Income Tax Crecdits (EITC) or from self-employment?
☐ YES ☐ NO If YES, complete the items below.

Name of Person Receiving the Earned Income	Type of Earned Income	Date Received or Expected	Gross Amount	How Often Received

SELF-EMPLOYMENT INCOME

26. Do you or anyone listed in Section 18 (page 3) own, singly or jointly with anyone else, any real or personal property (including inventory) that is used for business or self-employment? ☐ YES ☐ NO If YES, complete the items below:

Type	Persons Listed as Owners	Address/Description	Current Market Value	Amount Owed

OTHER INCOME

27. Do you or anyone listed in Section 18 (page 3) expect a change in your income (a new job, change in wages, settlement from legal action, etc.)? ☐YES ☐NO If YES, complete the items below:

Name of Person	Type of Change Expected	When	Amount Expected

28. Did you, your spouse, a former spouse or your parent (if you are a child) serve in the military? ☐ YES ☐ NO
If YES, complete the items below:

Name of Veteran	Dates the Veteran was in the Armed Forces	Veteran's Social Security Number or Claim Number	Veteran's Date of Birth

29. Have you, your spouse, a former spouse or your parent (if you are a child) ever worked for a federal, state, city, or county government or for an employer with a pension plan? ☐ YES ☐ NO If YES, complete the items below:

Name of Person Who applied	Employer	Dates of Employment

30. Have you, your spouse, a former spouse, or your parent (if you are a child) ever applied for Social Security or Railroad Retirement benefits? ☐YES ☐ NO If YES, complete items below:

Name of Person Who applied	Date Applied	Type Applied For	If Denied, Reason:

EXPENSES

31. Does your household have any of the following expenses: Food, Rent, Mortgage, Utilities, Property Taxes, or Insurance?
☐ YES ☐ NO If YES, complete the items below:

Name of Person Who Has Expense	Type of Expenses	Amount of Expense	How Often

32. Does anyone else pay all or a portion of the expenses listed in question 31? ☐ YES ☐ NO
If YES, complete the items below:

Name of Person Paying Expense	Type of Expenses	Amount Paid	To Whom Paid	How Often

MEDICAL COVERAGE

33. Do you or anyone listed in Section 18 (page 3) have Medicare coverage, Medicare Supplemental Insurance also called (Medigap) or have any other type of health or hospitalization insurance, paid by you, an employer, spouse or parent?
☐ YES ☐ NO If YES, complete the items below:

Name of Person Covered	Name of Policy Holder	Name, Address and Phone Number of the Insurance Company	Policy Number	Amount of Premium Paid

34. Do you have any injury or illness resulting from medical malpractice, or from an accident (pedestrian, automobile or other vehicle, on the job, etc.)? ☐ YES ☐ NO
If YES, complete the items below: ☐ Injury Referral Form (DE-124)

Name	Type of Accident	Date of Accident	Name and Address of Insurance or Company Responsible for Medical Costs Due to the Accident

35. Is anyone responsible for providing medical benefits, other than insurance, on your behalf or on your spouse's behalf?
☐ YES ☐ NO If YES, complete the items below:

Name of Person for Whom Benefits are Provided	Benefit Type	Name and Address of Insurance or Company Responsible for Medical Costs Due to the Accident

36. Have you incurred any medical expenses for the current month that are not covered by a third party (for example, dental services and dentures, hearing aids and batteries, eyeglasses and eye exams, chiropractic services)? ☐ YES ☐ NO
If YES, complete the items below:

Name of Person	Name of Insurance Company, Doctor, Hospital, etc.	Type of Service	Date Incurred	Total Medical Cost	Amount Paid by Insurance

BE SURE THAT YOU HAVE READ EVERY ITEM AND ANSWERED All QUESTIONS READ THE FOLLOWING CAREFULLY. MAKE SURE YOU SIGN AND DATE THE END OF THE FORM.

Social Security Number (SSN)

I understand AHCCCS will use my SSN to determine if I qualify for benefits with other programs and to obtain income and other information from:

- The Internal Revenue Service;
- The Social Security Administration;
- Arizona Department of Economic Security; and
- Other states administering TANF, Medicaid, Unemployment Insurance, Food Stamps, Programs under Titles I, X, XIV, and XVI of the Social Security Administration Act and other State Wage Information Collection Agencies.

Assignment of Rights to Other Benefits for Medical Care:

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.

Annuities

I understand that it is my responsibility to disclose all annuities purchased by my spouse or myself. I understand it is fraud for me or my representative to knowingly not disclose an annuity purchased by my spouse or myself. I understand that in order to be eligible for long term care services, that AHCCCS shall be named the primary beneficiary on any annuity purchased by my spouse or myself on or after July 1, 2006. When there is a spouse, disabled child, or minor child, AHCCCS may be named the secondary beneficiary.

Penalty Warning

I understand that Federal, State, and local officials will verify the information I provided on this form. If anything is inaccurate, I may be denied AHCCCS Medical Benefits. If I or my representative have knowingly provided false information, we will be subject to criminal prosecution. I also understand that:

1. I must not knowingly withhold, or give false information, with the intent to receive AHCCCS Medical Benefits, to which I am not entitled.
2. I will be required to pay back AHCCCS any benefits I receive as a result of withholding or giving false information, and I will be subject to criminal prosecution.
3. It is fraud for me or my representative to knowingly withhold information with the intent to receive medical benefits to which I am not eligible. If found guilty of fraud, I may be subject to fines, imprisonment, or other penalties as provided for by applicable State and federal laws.

Estate Recovery and TEFRA Liens Program

Congress passed a law in 1993 that requires Arizona to collect from the estates of individuals who, at age 55 or older, received long Term Care (Medicaid) assistance on or after January 1, 1994.

In addition, the law gave Arizona and other states the right to place TEFRA liens, as authorized under 42 U.S.C. §1396p, against the real property of certain permanently institutionalized nursing home members. AHCCCS files liens against property to recover the cost of AHCCCS benefits upon the member's death or the sale or transfer of the property. Liens can be placed against both home and non-homestead property.

For both Estate Recovery and TEFRA liens, the amount AHCCCS seeks to collect is the total amount of AHCCCS costs for that person during the period of time the person was on AlTCS. AHCCCS costs to be recovered include capitation payments, Medicare Part A and B premiums, co-insurance and deductibles, reinsurance, fee for service and any other payments made by AHCCCS. Capitation payments are monthly payments that AHCCCS pays to the Program Contractor to provide medical services.

AHCCCS Estate Recovery and TEFRA lien recovery applies only when a person was age 55 or older when long Term Care was received and there is no surviving spouse, child under 21 or a blind or totally disabled child.

I acknowledge that my Eligibility Specialist explained both the Estate Recovery program and TEFRA liens during the application interview and that I also received a copy of the Medicaid Assistance Estate Recovery Program brochure. I understand AHCCCSA may collect the cost of my care from my estate, or from my real property.

Information/Brochures
I have been provided with the following information as checked below:

- Estate Recovery Brochure *[all AL TCS applicants]*
- Rights and Responsibilities *[all applicants]*
- Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Brochure *[all applicants under age 21]*
- Women, Infant, Children (WIG) Supplemental Food Brochure *[all applicants who are pregnant, postpartum, or children under age]*
- How you Calculate the Share of Cost and my Share of Cost Estimate *[All ALTCS applicants]*
- Enrollment Choice Information *[all ACUTE & AL TCS EPO applicants in choice counties]*

Consent to Release Information
I authorize AHCCCS to investigate and contact any sources necessary to establish medical eligibility and the accuracy of financial information used to decide AHCCCS Health Insurance eligibility.

I give AHCCCS permission to release information to the Medicare intermediary or other insurance carrier for the purpose of determining the payment amount for Medicare covered services and to provide nursing facilities information regarding share of cost and source of income.

If the person applying is a child, I also give AHCCCS permission to release information to the Department of Child Support Enforcement (DCSE) to assist them in obtaining child and/or medical support. I understand that if I am an absent parent of a child who is not applying for AHCCCS Medical Benefits, AHCCCS will not release information to DCSE without additional consent from me.

Statement of Truth
I swear or affirm under penalty of perjury that the statements made regarding the persons in my home, and the income, resources, property and all other items that pertain to my possibly qualifying for AHCCCS Medical Benefits are true and correct to the best of my knowledge. I have read and understand all of the information on this application.

Applicant's Signature:		Date:	
Spouse's Signature:		Date:	
Witness' Signature (if applicant signed with a mark):		Date:	
Representative's Signature:		Date:	

AGENCY USE ONLY

AGENCY USE ONLY - CASE RECORDINGS

Pending Notice Due Date: