E-mail to MedicalManagement@AZAHCCCS.gov
DO NOT FAX

Type of Request	Type of Request	Date	Date

MEMBER INFORMATION

First Name	First Name	Last Name	Last Name
Date of Birth	Date of Birth	Gender	Gender.
Eligibility Status	Eligibility Status		
AHCCCS ID	AHCCCS ID	CMDP/DDD/CRS (Select all that apply)	☐CMDP ☐DDD ☐CRS ☐None
Current Diagnoses	1)Dx1	2)Dx2	3)Dx3
	4)Dx4	5)Dx5	6)Dx6
If this is an initial request, where is the member currently located? If this is an update, place "N/A" in the field below.			
Enter Text			

~~CONTRACTOR OR TRBHA~~ENTITY

~~Contractor or TRBHA Name~~Entity Name	Entity		
~~Contractor or TRBHA Contact Name~~Entity Contact Name	Entity Contact Name	~~Contractor or TRBHA~~ Entity Contact Phone	Entity Phone Number
~~Contractor/~~Entity Responsible for Physical Health	Entity		

ATTEMPTED PLACEMENT

This section only needs to be completed for initial requests. It does not need to be completed for 30-day updates, cancellations, or discharges.

PLACEMENT 1

Name	Name
City/State	City/State
Level of care	Level of Care
Reason for Barrier	Reason for Barrier

PLACEMENT 2

Name	Name
City/State	City/State
Level of care	Level of Care
Reason for Barrier	Reason for Barrier

PLACEMENT 3

Name	Name

City/State	City/State
Level of care	Level of Care
Reason for Barrier	Reason for Barrier
	~~PLACEMENT 4~~[1]
~~Name~~	
~~City/State~~	
~~Level of care~~	
~~Reason for Barrier~~	

OUT-OF-STATE PLACEMENT INFORMATION

For initial requests, what is the name of the proposed Out-of-State Placement?
Placement
Placement Address
Placement Address
AHCCCS Provider Registration Number
Level of Care
Level of Care

CLINICAL INFORMATION

Presenting issues that require placement out-of-state?
Enter text

How will the proposed placement meet the member's needs (e.g.~~i.e.~~ behavioral, physical, and educational)?
Enter Text

What are the treatment goals and objectives?
Enter Text

What are the discharge criteria? What progress has been made toward discharge?
Enter text.

Note any barriers preventing discharge and/or a return to in-state services. What are the strategies to overcome these barriers?
Enter text.

What is being done to address the network gap(s) resulting in the need to place the member out- of- state and when is the network expecting to be sufficient to meet the specific needs of this member?
Enter text.

[1] Deleted placement 4 as AHCCCS only requires 3

What is the plan and associated time line (including the date of tentative discharge) to return the member to in-state care and services? What aspects of the treatment plan are preparing the member for a less restrictive, community-based environment in-state? ~~Please i~~Include a list of in-state placements (contracted and non-contracted) that have been contacted to coordinate in-state placements/services.
Enter text.

Once returned to Arizona, what support services will be put in place to secure continued in-state progress?
Enter text.

Has contact with family been severed? ☐Yes ☐No

How are family/natural supports being provided to family/natural supports?
Enter text.

What, if any, services are being provided to family/natural supports?
Click here to enter text.

DISPOSITION

What was the date of admission to out-of-state placement? Date of out of state placement.
If still out-of-state, what is the projected discharge date? Projected discharge date.
What was the discharge date (if applicable)? Discharge date.
Length of stay approved? Length of stay approved.

REVIEWER INFORMATION

~~Contractor or TRBHA~~Entity/ Credentials/ Title of the person who completed the form/ Date
Enter text.

AHCCCS Reviewer Name/ Credentials/ Title / Date
Enter text.