ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ALTCS ENROLLMENT TRANSITION INFORMATION (ETI)

Sending Program Contractor: _____

Receiving Program Contractor: _____

Transition Date: _____ Rate Code: _____

Member's Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F

AHCCCS ID No.: _____ Primary Language Spoken: _____

Contact Person's Name: _____

Relationship *(Guardian, POA, etc.)*: _____ Contact Person's Phone No.: _____

PRIMARY HEALTH INSURANCE

Medicare No.: _____ Part *(check all that apply)*: ☐ A ☐ B ☐ D

Medicare Advantage – PDP: _____ SNP? ☐ Yes ☐ No

Name of Prescription Drug Plan (PDP): _____

Other: _____

MEMBER LOCATION

Current Address: _____ Phone No.: _____

Facility Name *(If applicable)*: _____

Type of Facility: ☐ Skilled Nursing Facility ☐ Assisted Living Facility (ALF) ☐ Behavioral Health

Admission Date: _____ Specialty Unit: _____

Level of Care: _____ ALF Room and Board Amount: _____

MEDICAL INFORMATION

Diagnoses: _____

Primary Care Physician's Name: _____ Primary Care Physician's Phone No.: _____

Specialist's Name *(Including out-of-area providers)*: _____

Type: _____ Phone No.: _____

Specialist's Name: _____

Type: _____ Phone No.: _____

Scheduled Appointments/Procedures: _____

Special Medications/Treatments: _____

Services Provided by Children's Rehabilitative Services (CRS): _____

Pending Physician Orders not Yet Completed: _____

DIALYSIS

Site Name: _____ Phone No.: _____

Address: _____

Treatment Days: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun Time(s): _____

Transportation Provider: _____

Assistance and/or Type of Transportation Required: _____

See page 3 for EOE/ADA disclosures

Member's Name: _____ Date of Birth: _____

DURABLE MEDICAL EQUIPMENT / SUPPLIES

Attach additional detailed documentation on DME / Supplies, as needed.

Type of Equipment: _____ ☐ Rent ☐ Own Provider: _____

Type of Equipment: _____ ☐ Rent ☐ Own Provider: _____

Type of Equipment: _____ ☐ Rent ☐ Own Provider: _____

Type of Equipment: _____ ☐ Rent ☐ Own Provider: _____

Supplies Needed: _____ Provider: _____

Supplies Needed: _____ Provider: _____

Supplies Needed: _____ Provider: _____

Pending Issues that Require Follow-Up: _____

PENDING GRIEVANCE? ☐ YES ☐ NO

Nature of Grievance: _____ Expected Resolution Date: _____

MEMBER HOSPITALIZED? ☐ YES ☐ NO

Complete this section if the Member is hospitalized on the date this form is completed.

Name of Hospital: _____ Phone No.: _____

Admission Date: _____ Admitting Diagnosis: _____

Inpatient Treatments: _____

Expected Discharge Date: _____ Discharge to: _____

COMMENTS / OTHER INFORMATION

HOME AND COMMUNITY BASED SERVICES (HCBS)

Check all that apply or attach Service Authorizations for details.

	PROVIDER'S NAME	PHONE NO.	FREQUENCY OF SERVICE
☐ Adult Day Health			
☐ Attendant Care			
☐ Home Delivered Meals			
☐ Homemaker/Housekeeping			
☐ Personal Care			
☐ Respite			
☐ Other			
☐ Emergency Alert			
☐ Home Health Nursing Payer Source:			
☐ Home Health Aide Payer Source:			
☐ Hospice Payer Source:			

Member's Name: _____ Date of Birth: _____

BEHAVIORAL HEALTH (BH)

BH Diagnosis: _____

BH Medications: _____

BH SERVICE	PROVIDER'S NAME	PHONE NO.	FREQUENCY OF SERVICE

Date of Last Judicial Review: _____ Outcome: _____

☐ COT Name On Court Order: _____ Expiration Date: _____

REQUIRED ATTACHEMENTS AND OTHER TRANSITIONING INFORMATION

☐ Last Support Coordinator assessment ☐ Last quarterly behavioral health consult, if applicable

☐ List of medications ☐ Contingency plan, if Member receiving critical services

☐ *Outpatient adult* physical therapy service No. of visits received for current contract year: _____

☐ Respite Hours Utilized ☐ Inpatient Days Utilized ☐ Support Coordinator Summary

☐ Advance directives *(living wills, medical powers of attorney, etc.)*, if applicable ☐ EPSDT forms, if applicable

☐ Guardian/conservatorship or power of attorney, if applicable

☐ Lifetime use of Community Transition Service (CTS) benefit CTS Date: _____

SIGNATURE

Support Coordinator's Name *(Please print)*: _____

Phone No.: _____ Date: _____