ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ACKNOWLEDGEMENT OF PUBLICATIONS / INFORMATION

Member's Name: _____ AHCCCS ID: _____

I was informed of the opportunity to choose my Support Coordinator. I understand my choice will be honored to the best of the District's ability.

I understand the member eligible for the Division must be present at all meetings.

I understand that if I have a Behavior Treatment Plan (BTP) the Program Review Committee will have access to my personal identifiable information for the performance of official duties. I understand the Independent Oversight Committee (IOC) will receive information about my BTP but the information will not include my personal identifiable information (e.g., full name, address).

I understand the Independent Oversight Committee (IOC) will receive information regarding any potential rights violations. The Independent Oversight Committee (IOC) will not receive any of my personal identifiable information. I understand I can raise a concern to the Independent Oversight Committee (IOC) about a possible violation of my rights by calling 1-844-770-9500.

The Division gave me a Statement of Rights (PAD-195) and Notice of Privacy Practices (DES-1077A). I may also go to the **Division's website**[1] to obtain a copy.

I understand the Division may disclose to providers any historical and behavioral information per A.R.S. 36-557 (N).

I understand the Support Coordinator may assist me in developing a disaster/emergency plan.

The Vendor Call Process was explained to me including the time frames and the auto-assignment process.

I understand the Planning Document will be sent to all team members unless otherwise indicated.

Additional Requirements for Specific Groups

I understand that the service offered through the ALTCS program are described in the ALTCS Member Handbook (DDD-0465A). The Handbook was given or offered to me. I may also go to the **Division's website** to obtain a copy. *(Required annually for all ALTCS members)*

The pamphlet, Decision About Your Healthcare (PAD-588), was given or offered to me. I may also go to the **Division's website** to obtain a copy. *(Required annually for all members age 18 and older)*

The Voter Registration information was given or offered to me. I may also go to **Arizona Secretary of State's website**[2] to obtain a copy. *(Required for members who do not have a legal guardian, and who are or will be 18 by the next general election)*

I was informed of my requirement to register with the Selective Service. *(Required for males at age 18.)*

I have been provided the ***How DDD Eligibility is Determined*** form (DDD-0640A). I understand that a redetermination of DDD Eligibility will be completed at ages 6 and 18. *(Required to be given to members 5 and 17 years old)*

_____ **Member/Responsible Person's Initial**

☐ Member has a SMI designation *(Check if applicable)*

The SMI Appeal & Grievance rights have been explained to me. The ALTCS Member handbook (DDD-0465A) has been given or offered to me. I may also go to the **Division's website** to obtain a copy.

_____ **Member/Responsible Person's Initial**

By signing below I am acknowledging that my Support Coordinator has informed me of all the above.

Member / Responsible Person's Signature: _____ Date: _____

Print Name of Support Coordinator: _____ Date: _____

1 https://des.az.gov/services/disabilities/developmental-disabilities
2 https://azsos.gov/elections/voting-election

See reverse for EOE/ADA disclosures

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local