AHCCCS is Arizona's Medical Assistance Program (Medicaid)

AHCCCS

Application for AHCCCS Health Insurance and Medicare Savings Programs

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

Keep Pages A, B, C, and D 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 Health Insurance and/or Medicare Savings Programs. Or, you can apply online at www.healthearizonaplus.gov.

How can I qualify for AHCCCS Health Insurance?

- Your gross monthly income can be no more than $990 for an individual or $1,335 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.

What medical services are covered by AHCCCS Health Insurance?

Prescription Medication *	Medical Supplies	Immunizations (shots)
Doctor's Office Visits**	Medically Necessary Transportation	Chemotherapy
Laboratory and X-ray Services	Medically Necessary Specialist Care	Emergency Medical Care
Hospital Services	Behavioral Health Care	Rehabilitation Services
	Dialysis	90 days of nursing care services

* AHCCCS prescription coverage is limited for people who have Medicare.
** Wellness visits for people age 21 and over are not covered.

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):	$0 - $990 (Individual) $0 - $1,335 (Couple)	$990.01 - $1,188 (Individual) $1,335.01 - $1,602 (Couple)	$1,188.01-$1,337 (Individual) $1,602.01-$1,803 (Couple)
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* * 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.	• Pays your Medicare Part B Premium	• Pays your Medicare Part B Premium

If you are a Qualified Disabled Working Individual (QDWI) who is under age 65 and who lost Title II Social Security Disability benefits because of earnings, use this application to apply for payment of your Medicare Part A premium.

What does AHCCCS Health Insurance cost you?

Premiums

Most people do not have to pay a monthly premium for AHCCCS Health Insurance. Some people with income too high to qualify for AHCCCS Health Insurance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are $10 - $35 per person for employed people with disabilities.

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 for prescriptions
- $3.40 to $4.00 for outpatient visits for evaluation and management services including doctors office visits
- $2.30 to $3.00 for physical, occupational or speech therapy

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

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

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services (CRS) program
- People who are temporarily 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 is limited to 90 days in a contract year.
- People who receive hospice care

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

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

How does AHCCCS Health Insurance work?

If you are approved for AHCCCS Health Insurance, you will receive your health care from an AHCCCS Health Plan unless:

- You are Native American and you choose American Indian Health Plan as your health plan
- You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Savings Programs, AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles, or
- AHCCCS can only pay for your emergency services because of your status with the United States Citizenship and Immigration Services (USCIS). 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 the 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.

Your Primary Doctor and Specialists

- You must choose your primary doctor or one will be assigned to you.
- Once enrolled, you will get a list of primary doctors in your area from the health plan.
- Your primary doctor will:
  - Take care of your health care.
  - Be the first person you go to for non-emergency medical care.
  - Be responsible for authorizing your non-emergency medical services.
  - Send you to a specialist when needed.
- You have the right to change your primary doctor at any time by calling your Health Plan's member or customer services.

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 health plan, your doctor must call the AHCCCS health 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 AHCCCS health plan.
- If you have Medicare, your prescription coverage under AHCCCS is limited. If you have questions about prescriptions, call 1-800-MEDICARE (1-800-633-4227) or your AHCCCS Health Plan.

Your AHCCCS ID Card

- Your AHCCCS ID Card has your unique AHCCCS ID number.
- Show the card when you get medical care (you may need to show a picture ID as well)
- Doctors, hospitals and pharmacists use your AHCCCS ID Card to obtain faster verification of your eligibility
- Keep your AHCCCS ID Card with you at all times
- Keep your AHCCCS ID Card in a safe place
- Do not let anyone else use your AHCCCS ID Card or you may be prosecuted.

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 Health Insurance 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 Health Insurance or for help to pay Medicare costs. You can check **YES** to either question or to both.

- Answer all questions on pages 1 through 3 for each person applying.
- If you need more room, attach additional sheets of paper to provide all requested details.
- Read page C 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, and E for your records and mail pages 1 through 3 to the office that sent this form to you. The addresses and telephone numbers of the offices are listed on the page 4.
- If you are applying for AHCCCS Health Insurance, read page D and choose an AHCCCS health 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 Administrative Legal Services, 701 East Jefferson, 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, Veteran's 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 Health Insurance 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 A HEALTH PLAN THAT SERVES YOUR COUNTY.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. Native Americans may choose American Indian Health Program or an AHCCCS Health Plan.
- Before choosing, check with your doctor, pharmacy or hospital, to see if they contract with (work with) the plan that you want. If you want more information about the doctors, specialists or hospitals that contract with a health plan that serves your county, call the number listed below for the health plan or ask your Eligibility Specialist for the health plan's list of health care providers.
- If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

APACHE COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-729-8000
If your zip code is 85943, you must choose from among the health plans listed under Navajo County.

COCHISE COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 520-295-2479

COCONINO COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-283-2501
If your zip code is 86336 or 86340, you must choose from among the health plans listed under Yavapai County.

GILA COUNTY
Health Choice Arizona 1-800-322-8670
University Family Care 1-800-582-8686
American Indian Health Program 928-475-2371
If your zip code is 85542, or 85550, you must choose from among the health plans listed under Cochise County.

GRAHAM COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 928-475-2686
If your zip code is 85643, you must choose from among the health plans listed under Cochise County.

GREENLEE COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 928-475-2371

LA PAZ COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
University Family Care 1-800-582-8686
American Indian Health Program 928-669-2137

MARICOPA COUNTY
Health Net of Arizona 1-888-788-4408
Care 1st Arizona 1-866-560-4042
Health Choice Arizona 1-800-322-8670
UnitedHealthcare Community Plan 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Maricopa Health Plan 1-800-582-8686
American Indian Health Program 602-263-1200

MOHAVE COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-769-2900
If your zip code is 86434, you must choose from the health plans listed under Yavapai County.

NAVAJO COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-338-4911

PIMA COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Care 1st Arizona 1-866-560-4042
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
American Indian Health Program 520-295-2479
If your zip code is 85645, you must choose from among the health plans listed under Santa Cruz County.

PINAL COUNTY
Health Choice Arizona 1-800-322-8670
University Family Care 1-800-582-8686
American Indian Health Program 520-562-3321
If your zip code is 85242 or 85220, you must choose from among the health plans listed under Maricopa County.
If your zip code is 85292 you must choose from among the health plans listed under Gila County.
If your zip code is 85192, you must choose from among the health plans listed under Cochise County

SANTA CRUZ COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Service 520-295-2479

YAVAPAI COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
University Family Care 1-800-582-8686
American Indian Health Program 602-263-1200
If your zip code is 85342, 85358 or 85390, you must choose from among the health plans listed under Maricopa County. If your zip code is 86351 you must choose from among the health plans listed under Coconino County.

YUMA COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
University Family Care 1-800-582-8686
American Indian Health Program 760-572-4100

IMPORTANT

When you have chosen a health plan you can either:

- Write your choice on Page 3, **OR**
- Call AHCCCS to pre-enroll. From area codes 480, 602 or 623 call (602) 417-7100 or from area codes 520 or 928 call 1-800-334-5283.
  When you call to pre-enroll, you will need to give the following information:
  - Name
  - Sex (male or female)
  - Date of birth, and
  - Social Security Number of all the individuals for whom you applied. Immigrants who are not legally able to obtain a SSN are not required to provide one.

If you have any questions about enrolling with an AHCCCS health plan, need an interpreter, or if you are visually or hearing impaired and need special accommodations to choose a health plan or to understand the information, from area codes 480, 602 or 623 call (602) 417-7100 or TDD (602) 417-4191 or from area codes 520 or 928 call toll free at 1-800-334-5283 or TDD 1-800-826-5140.

AHCCCS is Arizona's Medical Assistance Program (Medicaid)

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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	Age	Are you: ❑ Male or ❑ Female	Medicare Claim Number

Place of Birth ❑ U.S.A ❑ Other Country _____

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?
❑Asylee ❑Afghan/Iraqi Special Immigrant ❑Refugee
❑Battered Alien ❑American Indian Born in Canada ❑Conditional Entrant
❑ Cuban-Haitian Entrant ❑Deportation Withheld ❑ Hmong or Laotian Highlander
❑Indefinite Detainee ❑Lawful Permanent Resident (LPR) ❑Parolee for at Least One Year
❑Victim of Trafficking ❑Other

Home Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code

Home Phone Number	Work Phone Number	Message Number	Email 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 Tribe: _____
❑ 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:

Do you need help paying for medical bills from the last three months? ❑ Yes ❑ No
What months? _____ _____ _____

Would you like to register to vote? ❑ Yes ❑ No

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

Representative's First and Last Name	Representative's Relationship to You	Representative's Phone Number

Representative's Mailing Address	City, State	Zip Code	Email Address

By signing below, I:
- 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 AHCCCS;
- Give permission for AHCCCS or DES to tell my representative about my eligibility; and
- Agree to give personal information to my representative.

Signature of Applicant (not needed if you have a legal guardian or you are unable to sign because you are incapacitated):	Date:

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 Health Insurance? ❑ 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

Would your spouse like to register to vote? ❑ Yes ❑ No

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 Tribe:_____
❑ 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 spouse's immigration card?
A_____

What is your spouse's immigration status?

❑Asylee
❑Battered Alien
❑ Cuban-Haitian Entrant
❑Indefinite Detainee
❑Victim of Trafficking
❑Afghan/Iraqi Special Immigrant
❑American Indian Born in Canada
❑Deportation Withheld
❑Lawful Permanent Resident (LPR)
❑Other
❑Refugee
❑Conditional Entrant
❑ Hmong or Laotian Highlander
❑Parolee for at Least One Year

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 No. (optional)	Type of School, If Student
A.				
B.				

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 Administration?	❑ 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? ❑ Yes ❑ No
If Yes, complete below. If you need more room, attach a separate piece of paper with the information requested.

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? ❑ Yes ❑ No
If YES, complete the information below and SEND A COPY OF THE INSURANCE ID CARD.

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.)? ❑ Yes ❑ No
If YES, complete the items below:

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 Health Insurance 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.

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.

q Yes q 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 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 www.azsos.gov/election/voterinformation.htm.

HEALTH PLAN CHOICE

If you are applying for AHCCCS Health Insurance, choose an AHCCCS health plan that serves your county. See page D or a list of health plans.

Name of Health Plan you Choose (from page D)

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 Health Insurance 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 C 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

AHCCCS OFFICES

SSI MAO

Complete and mail pages 1 – 3 of the application to:
801 E. Jefferson, MD 3800
Phoenix, AZ 85034

- Calling from area codes (602, 480 or 623) dial (602) 417-5010 and choose option 5.
- Calling from area codes (520, 760 or 928) dial toll free 1-800-528-0142.

Freedom to Work (FTW)

Applying for Employed People with Disabilities
Complete and mail pages 1 – 3 of the application to:
801 E. Jefferson, MD 3800
Phoenix, AZ 85034

- Calling from area codes (602, 480 or 623) dial (602) 417-6677.
- Calling from area codes (520, 760 or 928) dial toll free 1-800-654-8713, Option 6.

CASA GRANDE
500 North Florence Street
Casa Grande, Arizona 85222
(520) 421-1500
1-855-277-0260 (area codes 602, 480, or 623)

CHINLE
Tseyi Shopping Center, Hwy 191
PO Box 1942
Chinle, Arizona, Navajo Nation, 86503
(928) 674-5439 (area codes 520, 760, or 928)
1-888-800-3804 (area codes 602, 480, or 623)

COTTONWOOD
1500 E. Cherry Street
Suite I
Cottonwood, Arizona 86326
(928) 634-8101 (area codes 520, 760, or 928)
1-855-873-0393 (area codes 602, 480, or 623)

FLAGSTAFF
2717 North Fourth Street, Suite 130
Flagstaff, Arizona 86004
(928) 527-4104 (area codes 520, 760, or 928)
1-800-540-5042 (area codes 602, 480, or 623)

GLOBE/MIAMI
Cobre Valle Plaza
2250 Highway 60, Suite H
Miami, Arizona 85539-9700
(928) 425-3165 (area codes 520, 760, or 928)
1-888-425-3165 (area codes 602, 480, or 623)

KINGMAN
519 East Beale Street, Suite 130
Kingman, Arizona 86401
(928) 753-2828 (area codes 520, 760, or 928)
1-888-300-8348 (area codes 602, 480, or 623)

LAKE HAVASU CITY
2160 North McCulloch Blvd., Suite 105
Lake Havasu City, Arizona 86403
(928) 453-5100 (area codes 520, 760, or 928)
1-800-654-2076 (area codes 602, 480, or 623)

PHOENIX
801 East Jefferson Street
Phoenix, Arizona 85034
(602) 417-6600 (area codes 602, 480, or 623)
1-800-528-0142 (area codes 520, 760, or 928)

PRESCOTT
3262 Bob Drive Suite #11
Prescott Valley, Arizona 86314
(928) 778-3968 (area codes 520, 760, or 928)
1-888-778-5600 (area codes 602, 480, or 623)

SIERRA VISTA
Street Address: 820 East Fry Blvd,
Sierra Vista, Arizona
Mailing: 1010 North Finance Center Drive, Suite 201
Tucson, Arizona 85710
(520) 459-7050 (area codes 520, 760, or 928)
1-888-782-5827 (area codes 602, 480, or 623)

TUCSON
1010 North Finance Center Drive, Suite 201
Tucson, Arizona 85710
(520) 205-8600 (area codes 520, 760, or 928)
1-800-824-2656 (area codes 602, 480, or 623)

YUMA
3850 West 16th Street, Suite A
Yuma, Arizona 85364
(928) 782-0776 (area codes 520, 760, or 928)
1-855-419-6527 (area codes 602, 480, or 623)