MEMBER NAME *AHCCCS ID #*

We, the individuals who have signed on the next page, choose to have Arizona Long Term Care System (ALTCS) pay _____ (the spouse) for _____'s (the member's) care. We know and agree that:

- The ALTCS Case Manager will decide the number of hours that will be paid for _____'s (the member's) care,
- All services shall be medically necessary and cost effective,
- We cannot have more than 40 hours of Attendant Care (or similar services) in a seven-day period, and
- We shall comply with Electronic Visit Verification (EVV) requirements including both AHCCCS and agency specific policies and practices.

We know and agree that if _____ (the spouse) is paid for giving care:

- The spouse is employed with a provider agency and will be receiving earned income,
- There will be an increase in the earned income of _____ (the spouse),
- The extra income could cause us to lose benefits from other publicly funded programs; and
- This change in benefits could affect us and/or others in our household.

Publicly funded programs may include but are not limited to the following:

BENEFIT TYPE	AGENCY RESPONSIBLE
AHCCCS, ALTCS and/or KidsCare eligibility	AHCCCS
Supplemental Security Income (SSI)	Social Security Administration
Medicare Part D Low Income Subsidy	Social Security Administration
Nutrition Assistance (Formerly the Food Stamp Program)	Arizona Department of Economic Security
Temporary Assistance to Needy Families (TANF)	Arizona Department of Economic Security
General Assistance	Arizona Department of Economic Security
Housing and Urban Development (HUD) Housing	Local Housing Authority
Social Security Disability	Social Security Administration
Qualified Medicare Beneficiary (QMB)	AHCCCS
Specified Low-Income Medicare Beneficiary (SLMB)	AHCCCS
Qualified Individual – 1 (QI-1)	AHCCCS
Other:	
Other:	

Effective Dates: 10/01/07, 01/01/16, 10/01/17, 01/20/22
Approval Dates: 01/01/16, 07/25/17, 10/21/21

We know it is up to us to get in touch with any agencies from whom anyone in our household receives benefits.

We shall:

- Talk about how a change in the income for _____ (the spouse) may affect those benefits,
- Talk about this before making a decision to pay _____ (the spouse) for care, and
- Tell any agency from whom we currently receive benefits of the change in income if/when we decide to pay _____ (the spouse) for care.

We understand that some or all of our publicly funded benefits could be stopped or reduced. This depends on the amount of income _____ (the spouse) receives as an ALTCS paid caregiver. We will ask _____'s (the member's) ALTCS case manager for assistance if we need it.

We also know:

- We can change our minds about _____ (the spouse) being paid for care at any time,
- We can decide that _____ (the member) can receive other ALTCS services, and
- These services shall be medically necessary and cost effective.

SIGNATURE OF MEMBER: _____ DATE: _____

SIGNATURE OF SPOUSE: _____ DATE: _____

SIGNATURE OF CASE MANAGER: _____ DATE: _____

ANNUAL REVIEW OF CHOICE FOR SPOUSE ATTENDANT CARE

My spouse has been my paid ALTCS caregiver. I wish to continue with that plan. I know that there are other agencies and caregivers who could provide my care. I know that by choosing my spouse, I only get **up to** 40 hours of Attendant Care (or similar services) in a seven-day period.

SIGNATURE OF MEMBER: _____ DATE: _____

SIGNATURE OF MEMBER: _____ DATE: _____

SIGNATURE OF MEMBER: _____ DATE: _____

SIGNATURE OF MEMBER: _____ DATE: _____

SIGNATURE OF MEMBER: _____ DATE: _____

cc: Member Case file