Exhibit 1620-2, ALTCS Member Change Report

Member Name	*AHCCCS ID:*	*Date*

ALTCS Contractor:		Reported By:	Phone #:
Sent To: ❑ ALTCS Local Office ❑ DHCM ❑ Medical QC Supervisor		DOB:	Customer #:
Verification Attached? ❑ YES ❑ NO	Verification Type: ❑ DE-130 ❑ Case Notes ❑ Other: _____		

Part I - Demographic/Miscellaneous

❑ **Address Change:**
❑ Residential ❑ Move to Home in Different Fiscal County
❑ Mailing ❑ Move Out of State

For: ❑ Representative ❑ Member

Effective Date: ___/___/___

❑ Name ❑ Sex ❑ DOB
❑ Phone # ❑ SSN ❑ DOD ❑ Other:

Explain Change:

Part II - Placement/Living Arrangement

FROM: (previous residence) Enter facility name (if applicable), address and phone number. **TO:** (new residence) Check living arrangement. (Abbreviations in parentheses are used by the ALTCS local offices). Effective date: Indicate effective date of change. Length of Stay: Indicate length of stay and if temporary, enter date. Facility Status: Check facility Status (if applicable). Enter facility name (if applicable), address, and phone number. Enter comments.

FROM:		Phone: ( )	
Address:	City:	State:	Zip Code:

TO: Living Arrangement	**Effective Date:**	**Length of Stay:**	**Facility Status:**
❑ NF/ICF ❑ Home ❑ Adult Foster Care Home * ❑ Assisted Living Home * ❑ Assisted Living Center * ❑ Behavioral Health Residential ❑ Behavioral Health Supportive Home ❑ DD Group Home/Adult Developmental Home ❑ Child Developmental Foster Home/Large Group Setting ❑ Alternative Acute Living Arrangement ❑ Loss of Contact ❑ Other _____	___/___/___	❑ Permanent ❑ Temporary Until: ___/___/___ ❑ Unknown	❑ Medicare Certified ❑ Not Medicare Certified ❑ Licensed ❑ Unlicensed ❑ Contracted with Contractor ❑ Not Contracted with Contractor

Note to Local Office:

To change from Acute to LTC call the Technical Service Center in addition to entering the change in ACE.

* If not registered with AHCCCS or licensed by ADHS or OBHL, use Alternative Acute Living Arrangement.

Facility Name:	Provider ID:	Phone: ( )	
Address:	City:	State:	Zip Code:
Comments:			

Effective Dates: 07/04, 10/07, 01/01, 01/12, 10/13, 01/16, 10/01/17, 09/15/21
Approval Dates: 07/04, 10/07, 01/11, 01/12, 05/12, 10/13, 01/16, 07/25/17, 09/02/21

Member Name	*AHCCCS ID:*	*Date*

PART III - CLIENT STATUS

SEND THE DE-701 TO THE ALTCS LOCAL OFFICE TO REPORT THE FOLLOWING CHANGES:

- ❑ Member requests voluntary withdrawal from ALTCS (DE-130 attached)
- ❑ Change Contract Type from LTC to Acute for retroactive period (refusing services)
- ❑ Temporarily Absent from Arizona ❑ Returned to Arizona
- ❑ Tribal Enrollment Change – DHCM was contacted ❑ On-Reservation ❑ Off-Reservation

SEND THE DE-701 TO DHCM FOR THE FOLLOWING CHANGES:

- ❑ From LTC to Acute– (Attach case notes)
  - ❑ Services not available ❑ Temporarily out of service area
  - ❑ Refusing Services (DE-130 not signed)
- ❑ From Acute to LTC
  - ❑ Services are available ❑ No longer out of service area
  - ❑ No longer Refusing Services

Date From: __/__/__

Date To: __/__/__

Comments:

PART IV - CHANGE CONTRACTOR WITHIN MARICOPA COUNTY

❑ Member Requests Enrollment Change to: _____(Contractor)

REASON:

❑ Erroneous Information/Error ❑ Family Continuity ❑ Lack of Choice ❑ Continuity of Placement

COMMENTS:

PART V - MEDICARE/OTHER HEALTH INSURANCE

Medicare Part A ❑ YES ❑ NO Effective Date: __/__/__

Medicare Part B ❑ YES ❑ NO Effective Date: __/__/__ Disenrollment Date: __/__/__

Other Insurance ❑ YES ❑ NO Effective Date: __/__/__

Medicare Number: _____

Policy Number: _____

INSURANCE CARRIER:

PART - SHARE OF COST

❑ Reduce Share of Cost Due to Death of Member

❑ Other (Specify):

Effective: Month/Year __/__

PART VII - INCOME/RESOURCE CHANGE

❑ Income ❑ Resources Explain the change:

Source or Type: _____

PART VIII - VENTILATOR STATUS CHANGE/PAS REASSESSMENT REQUEST (REFER TO THE ALTCS MEMBER CHANGE REPORT USER GUIDE)

❑ Ventilator Dependent ❑ Non-Ventilator Dependent Effective date: _____

❑ PAS Reassessment Request – Check Reason for Assessment and provide comment

❑ Improvement in functional abilities or medical condition to the extent that the member may no longer be medically eligible. Explain the change in comments.

❑ Transitional member now in NF; expected to exceed 90 days: (Complete Part II)

❑ Other (Explain):

Comments:

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Member Name | *AHCCCS ID:* | *Date*

RESPONSE (COMPLETED BY AHCCCS EMPLOYEE)

- ❑ Refer to Part(s) _____
- ❑ Change Completed
  - Date Completed ___/___/___
  - Effective Date ___/___/___
- ❑ Member no longer eligible
  - Effective Date ___/___/___
  - ❑ Failed PAS
  - ❑ Other Reason _____
- ❑ Member still eligible
  - ❑ Passed PAS Reassessment
  - ❑ DHCM has determined LTC status should continue
- ❑ Contract Type Change from __ to _____
  - Begin date _____ End date _____
- ❑ SOC increased to $ _____ Effective Date: __/__/__
- ❑ SOC decreased to $ _____ Effective Date: __/__/__
- ❑ Income Changed
- ❑ Resources Changed
- ❑ Member eligible for acute care only
  - Effective Date ___/___/___
  - ❑ ALTCS Acute care
  - ❑ Health Plan _____
- ❑ No Action Taken (see comments)

Comments:

Signature of AHCCCS Staff Person _____ Date Returned ___/___/___

An electronic Member Change Report (MCR) shall be sent to AHCCCS to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.).
- To report a change in the member's financial status (or that of their household) which may affect their Arizona Long Term Care System (ALTCS) eligibility, including the initiation of the member's spouse as the paid caregiver.
- To report a change in an ALTCS member's placement.
- To report a change in the member's DDD status and request a Pre-Admission Screening (PAS) reassessment.
- To report the closure of a member's service plan for reasons other than financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program).
- To initiate a Contractor change for a member who is Elderly and/or has Physical Disabilities (E/PD) when the member moves into another Contractor's service area in a Home and Community Based (HCB) setting (does not include alternative residential settings).
- To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs.
- To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to a nursing home or Intermediate Care Facility (ICF) and is expected to stay more than 90 continuous days (this request must be sent within 45 days of admission to the institutional setting).
- To request an Acute Care Only determination for a member who has received no Long Term Care (LTC) services for a full calendar month because they refuse ALTCS covered services, but they have not signed a Voluntary Withdrawal. "Refusing" includes being unwilling or unavailable to receive services offered or covered by the Contractor (examples: member is not home whenever provider comes to deliver care, member is unwilling to move out of non-contracted alternative residential setting or member is temporarily out of

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Member Name *AHCCCS ID:* *Date*

contractor's service area). This determination could result in the member being disenrolled from ALTCS if their income exceeds 100% of the Federal Benefit Rate.

- To request a change in a member's status from Acute Care Only back to full LTC when the member begins to accept LTC services.
- To request a change in Contract Type when a member has received no LTC services for a full calendar month, due to no LTC service provider being available. This change will not cause a member to be disenrolled.
- To inform ALTCS when a member is temporarily out-of-state (>30 days).
- For Maricopa County E/PD members only – to report the member's request to change Contractors and the need for an enrollment choice.
- To report loss of contact with the member.

NOTE – Members who are temporarily out of the Contractor's service area including out of state, may be provided with LTC services if these are available, in the member's best interests and are approved by the contractor. No AHCCCS services may be provided while a member is outside of the United States.

A hard copy MCR may be needed if, at the time of submission, the member is no longer enrolled with the Contractor that is attempting to send the report.