



ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Committed to Excellence in Health Care

August 19, 1998

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7500 Security Blvd.
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Joan:

The following are Arizona's responses to HCFA questions on the Title XXI State Plan. If you have any questions about the responses, please call me at (602) 417-447.

Section 1

1. **Please provide an assurance that the title XXI State plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.**

AHCCCS assures that the Title XXI State Plan will be conducted in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000[d] et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70[b]) and the regulations at 45 C.F.R. Parts 80 and 84. No individual shall be subject to discrimination under this State Plan on the grounds of race, color, national origin or handicap.

Section 4.1.8

2. **The description of the KidsCare eligibility determination process refers to an "AHCCCS eligibility office" (page 18). Since these do not currently exist as part of the Medicaid acute care program in Arizona, please provide some information on the location and functioning of these offices. How do these offices differ from the AHCCCS KidsCare Unit described in section 5.1 (page 30)? How will these offices interface with the Department of Economic Security offices where most Medicaid eligibility in Arizona's acute care program is determined?**

The AHCCCS eligibility office referred to on page 18 is the new KidsCare Unit that AHCCCS established to process applications and make determinations of eligibility. This office is located at 920 East Madison in Phoenix, which is one block from the AHCCCS administrative offices on West Jefferson. It is the same office referred to as the KidsCare Unit described on page 30. In addition to housing the KidsCare Unit, this office will also house the SSI-MAO Unit which handles the acute care eligibility determinations for the

SSI-related MAO eligibility groups such as Disabled Adult Children and Disabled Widow/Widowers and disabled children who lose their SSI because they did not meet the new disability criteria. The SSI-MAO is also responsible for the SSI ex parte Medicaid decisions.

In this new office, four or five staff from the Department of Economic Security (DES) will be co-located with KidsCare staff. The DES staff will determine Medicaid eligibility for children who appear to be Medicaid eligible.

Section 4.1.9

3. Section 36-2983. D. of Senate Bill 1008 states that an applicant must have or secure a Social Security Number as a condition of eligibility. Section 4.1.9 implies that an SSN is not required under KidsCare, only under Medicaid. Please clarify.

The requirement for a Social Security Number was added to Senate Bill 1008 prior to HCFA guidance on this issue. We will request the legislature to delete the mandatory language and replace it with permissive language in the 1999 legislative session. In the interim, we will follow HCFA guidance and not require a Social Security Number unless it appears that the child is Medicaid eligible.

Section 4.3

4. The proposal states that “the applicant must enter their choice of a provider on the application” (page 22). What will AHCCCS do in cases in which an applicant is unwilling or unable to select a provider at the time of application?

The KidsCare program provides many options for health care providers, including direct service community health centers. Therefore, a child or parent/legal guardian must make a choice before a child is enrolled in the program. If no choice is made, AHCCCS will follow-up with a phone call or letter to determine which provider the family wants to deliver KidsCare services.

Section 4.4.3

5. Arizona states that an exception to the six month look back period for health insurance coverage will be granted for persons transitioning from the Premium Sharing Program (PSP), which is State-funded (page 24). However, according to section 2110(b)(3), this exception applies only to State-funded health insurance programs in operation since before July 1, 1997. PSP did not begin delivering services until February 1, 1998. Please address. Also, please confirm that the other State funded programs (MN/MI, EAC, and ELIC), which are expected to convert most of their enrollees under the age of 19 to KidsCare (as stated in section 5.2 on page 31), have been in operation since before July 1, 1997.

Application for KidsCare/AHCCCS (Medicaid)

No Cost or Low Cost Health Insurance For Children Under Age 19

Source Code

If you have questions or need help filling out this application call:

(602)417-5437 (Phoenix) or call toll free 1-877-764-5437 (Statewide).

Para conseguir esta aplicación en español llame gratis al 1-877-764-5437, o en el área de Phoenix al (602)417-5437.

Mail your application when filled out to:

KidsCare, Mail Drop 500; 920 E. Madison; Phoenix, AZ 85034

How Did You Hear About KidsCare?

Please let us know how you heard about KidsCare by marking one or more of the boxes below.

- Notice in the Mail
- Doctors Office/Health Center
- School
- Community Assistance like:
 - Food Banks
 - Homeless Shelters
 - Head Start
 - Health Fairs
 - Migrant Farm Workers
 - County Health Clinic/
Immunization (Shots)
Site
 - Community Health Worker
 - Church
 - IHS/Tribal Health Clinic
 - Neighborhood Youth Center
 - Fast Food
 - Convenience Store (such as Circle K or 7-11)
 - Radio/TV
 - Promotional Event
 - Internet
 - Other

TO SPEED UP THE PROCESSING OF YOUR
APPLICATION SEND THE INFORMATION ASKED FOR
BELOW.

1. Complete all items and answer all questions using a pen and print your answers.
2. Send the information asked for with this application to help us find out if the children in your home qualify for KidsCare Health Insurance or other medical services through AHCCCS.
3. KidsCare Income Limits
(effective 10/1/99)

Family Size	Annual Income	Monthly Income
1	\$16,480	\$1,374
2	\$22,120	\$1,844
3	\$27,760	\$2,314
4	\$33,400	\$2,784
Additional Members	+\$5,640	+\$470
4. Insurance Premium is based on family income and number of children. Example: Family of 4 with income of \$2088 or less monthly will have no premium. The most you would have to pay is \$15 per month for one child or \$20 per month for 2 or more children. See page 6 for more details.



IMPORTANT: Anyone may send in the application, but if a parent lives with the child(ren) the parent should complete this form. If the person filling out the application does not live in the home, enter the name and address of the head of the household in which the child(ren) live.

1. Name (Last, First, M.I.) (Parent /Legal Guardian/Other Relative)

Home Address	City	State	Zip Code	County	Relationship to child(ren)	Home Phone Area code ()
Mailing Address	City	State	Zip Code	County	Message Phone Area code ()	Work Phone Area code ()

2. List information about all the child(ren) in the home, even if not applying for KidsCare.

a. Is this child applying for KidsCare?	b. Name	c. Birthdate and Sex	d. Race for statistical purposes only (Not Required)	e. Social Security Number (SSN)	f. Child's Mother & Father (if living in the home)
<input type="checkbox"/> Yes	Child #1 Last: _____	/ / / mm dd yy □ M □ F	<input type="checkbox"/> White <input type="checkbox"/> African Amer. <input type="checkbox"/> Asian	SSN (required for Medicaid only) _____	Mother: Father: Spouse:
<input type="checkbox"/> No	First: _____	<input type="checkbox"/> M.I.: _____	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native Amer. <input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Already on AHCCCS	First: _____	<input type="checkbox"/> M.I.: _____	_____	_____	_____
<input type="checkbox"/> Yes	Child #2 Last: _____	/ / / mm dd yy □ M □ F	<input type="checkbox"/> White <input type="checkbox"/> African Amer. <input type="checkbox"/> Asian	SSN (required for Medicaid only) _____	Mother: Father: Spouse:
<input type="checkbox"/> No	First: _____	<input type="checkbox"/> M.I.: _____	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native Amer. <input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Already on AHCCCS	First: _____	<input type="checkbox"/> M.I.: _____	_____	_____	_____
<input type="checkbox"/> Yes	Child #3 Last: _____	/ / / mm dd yy □ M □ F	<input type="checkbox"/> White <input type="checkbox"/> African Amer. <input type="checkbox"/> Asian	SSN (required for Medicaid only) _____	Mother: Father: Spouse:
<input type="checkbox"/> No	First: _____	<input type="checkbox"/> M.I.: _____	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native Amer. <input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Already on AHCCCS	First: _____	<input type="checkbox"/> M.I.: _____	_____	_____	_____
<input type="checkbox"/> Yes	Child #4 Last: _____	/ / / mm dd yy □ M □ F	<input type="checkbox"/> White <input type="checkbox"/> African Amer. <input type="checkbox"/> Asian	SSN (required for Medicaid only) _____	Mother: Father: Spouse:
<input type="checkbox"/> No	First: _____	<input type="checkbox"/> M.I.: _____	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native Amer. <input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Already on AHCCCS	First: _____	<input type="checkbox"/> M.I.: _____	_____	_____	_____
<input type="checkbox"/> Yes	Child #5 Last: _____	/ / / mm dd yy □ M □ F	<input type="checkbox"/> White <input type="checkbox"/> African Amer. <input type="checkbox"/> Asian	SSN (required for Medicaid only) _____	Mother: Father: Spouse:
<input type="checkbox"/> No	First: _____	<input type="checkbox"/> M.I.: _____	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native Amer. <input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Already on AHCCCS	First: _____	<input type="checkbox"/> M.I.: _____	_____	_____	_____

3. List parents and/or other adults living in the home.

Parent/Adult #1	Name	Birthdate and Sex	Relationship to Children	Social Security Number (SSN)	SSN (optional/not required)
Last _____	First _____	M.I. _____	/ / / mm dd yy □ M □ F	SSN (optional/not required) _____	_____
Parent/Adult #2	First _____	M.I. _____	/ / / mm dd yy □ M □ F	SSN (optional/not required) _____	_____

5. Does

6. List Mott Name

7. The result Where Attached cover