Member Name	*Date of Birth*	*AHCCCS ID #*

SECTION A: TO BE COMPLETED BY THE CASE MANAGER

Tribal contractor: _____

Current residence/placement: _____

Diagnosis/condition necessitating this placement: _____

_____

Distance from requested Nursing Facility to nearest family: _____

Level of involvement by family: _____

_____

Description of facility's program(s) that makes this placement appropriate for the member:

_____

_____

Information about Arizona Nursing Facilities that were ruled out for this member:

_____

Discharge plan for member's return to Arizona placement:

_____

_____

_____

Indicate requested Nursing Facility:

_____

☐ **San Juan Manor**
806 W. Maple
Farmington, NM 87401
Provider ID # 841826

☐ **Four Corners Care Ctr**
818 N. 400 West
Blanding, UT 84511
Provider ID# 028861

☐ **Bloomfield Nursing**
803 Hacienda Lane
Bloomfield, NM 87413
Provider ID# 518208

☐ **Red Rocks Care Ctr.**
3720 Church Rock Rd.
Gallup, NM 87301
Provider ID# 518176

☐ **Hurricane Health & Rehab**
416 N State St
Hurricane, UT 84737-1875
Provider ID # 443947

☐ **St. George Rehab**
1032 E 100 S.
St. George, UT 84770
Provider ID# 298987

Primary Care Physician (PCP) Name: _____ **AHCCCS Provider ID:** _____

By signing below the case manager understands AHCCCS approvals are generally given for six month intervals. The case manager shall submit a new Placement Request Form for renewal if the out-of-state placement is expected to continue beyond the initial approved time period. ***Requests for renewals shall be submitted prior to the expiration of the previous approval.***

Case Manager: _____ **Date:** _____

Section B: To Be Completed by AHCCCS

☐ **Approved** _____ _____ _____ _____
From Date *To Date* *Name and Title* *Date*

☐ **Denied** _____ _____ _____
Denial Date *AHCCCS Medical Director or designee* *Date*

Effective Dates: 10/01/17, 10/01/21
Approval Dates: 07/25/17, 09/02/21