AHCCCS is Arizona's Medical Assistance Program (Medicaid)

Application for Enrollment into AHCCCS Children's Rehabilitative Services

Please return application and all required documentation to:
Fax: 602-252-5286
Mail: AHCCCS-CRS
Attn: CRS Enrollment
801 E. Jefferson St.
MD 3500
Phoenix, AZ 85034
For questions contact the CRS Enrollment Unit at: 602-417-4545 or 1-855-333-7828

SECTION 1: APPLICANT INFORMATION

Does the applicant have AHCCCS? ❑ YES ❑ NO
If yes: AHCCCS ID Number: ________________________ AHCCCS Health Plan: ________________________
If no: has an application been submitted? ❑ YES ❑ NO

Child's First Name	M.I.	Child's Last Name

Date of Birth	Age	Gender: ❑ Male ❑ Female	Child's Social Security Number

Parent/Representative's First Name	Parent/Representative's Last Name

Relationship to Child: ❑ Parent ❑ Foster Parent ❑ Legal Guardian ❑ Representative ❑ Other: ________________

Parent/Representative's Mailing Address	City	State	Zip Code

Phone Number	Alternate Phone Number	Email Address

Name of Child's Primary Care Provider	Phone Number
Address, City, State, Zip Code	Email Address

List Primary Diagnosis: **Please send medical records with this form.**
1. ________________________ 2. ________________________ 3. ________________________

Planned Treatment:
____

SECTION 2: REFERRAL INFORMATION

The individual making the referral verifies that the child's parent/representative listed in Section 1 has been notified of this referral. If expedited request, please contact AHCCCS CRS Enrollment.

Name of Person Making Referral (First, Last)	Address, City, State, Zip Code	Phone Number

Relationship to Child: ❑ Parent ❑ Legal Guardian ❑ Provider ❑ Social Worker ❑ Self ❑ AHCCCS Contractor ❑ Other: ________________________

SECTION 3: AUTHORIZATION TO RELEASE INFORMATION (TO BE COMPLETED BY PARENT/REPRESENTATIVE)

AHCCCS cannot share information about a child's CRS enrollment without signed consent from the parent/representative listed in Section 1. Please provide the medical provider or referral source contact information and sign below to authorize AHCCCS to release information about the AHCCCS CRS decision.

Medical Provider/Referral Source Name	Phone Number	Email Address	
Mailing Address	**City**	**State**	**Zip Code**

I ________________________(full name of parent/representative listed in Section 1) give my consent to the Arizona Health Care Cost Containment System's (AHCCCS) Children's Rehabilitative Services (CRS) to share any information with the above named provider relating to the receipt of ________________________(full name of child) CRS application, application processing time, and the final CRS decision.

________________________ ________________________
Signature of Parent/Representative Date

<<Form Number>>