Arizona – October 2023

Welcome to the community

Long Term Care Member Handbook

Handbook revised October 2023.
Covered services are funded under contract with AHCCCS.

CSAZ23MD0147557_000

United Healthcare Community Plan

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Important information

Member Services . . . . . **1-800-293-3740**, TTY/TDD **711**
8:00 a.m.–5:00 p.m. Arizona time, Monday–Friday, excluding State holidays
After-hours **1-800-377-2055**

Urgent or emergency care:

If you need urgent care, your PCP should see you within 48 hours. Urgent Care centers are also available in our network of providers. If you need emergency care, your PCP should see you that day. For life-threatening emergencies, call 911 or go to the nearest emergency room.

Websites

UHCCommunityPlan.com
This is the site for members of UnitedHealthcare Community Plan. Visit this site if you have UnitedHealthcare Community Plan.

www.HealtheArizonaPlus.gov
This website will introduce people to the new requirements for AHCCCS Health Insurance and KidsCare eligibility, and connect to the Federal Insurance Marketplace.

Your health providers

Be sure to fill in the blanks so you will have these numbers ready.

My ALTCS ID# is: _____

My Case Manager's name is: _____

My Case Manager's phone number is: _____

My doctor's name is: _____

My doctor's phone number is: _____

My doctor's address: _____

My dentist: _____

Pharmacy: _____

Behavioral Health providers: _____

Behavioral Health crisis: Call **1-844-534-HOPE(4673)** or **988**. You may also text **4HOPE (44673)**.

My numbers for non-emergency transportation are:

Medical Transportation Brokerage of Arizona (MTBA)

Reservation line . . . . . **1-888-700-6822**, TTY **711**
(Call this number for a ride.)
Reservations should be made Monday–Friday, from 8:00 a.m. to 5:00 p.m. local time. Please call at least 3 business days in advance (excluding weekends and holidays) to make a reservation, but not more than 2 weeks before your scheduled appointment.

Case Manager . . . . . **1-800-293-3740**, TTY **711**
Your Case Manager helps set up services for you and will help you with any behavioral health, medical or social service needs. If you do not have your Case Manager's name or phone number, contact Member Services.

Medical management/prior authorization . . . . . **1-800-293-3740**, TTY **711**
Providers may be required to get approval before a service is rendered. If you have questions about this process or the authorization, contact your Case Manager or Member Services.

Dental . . . . . **1-800-293-3740**, TTY **711**
If you need help with understanding benefits, or information on available dental providers, contact your Case Manager or Member Services.You may also find benefit information and dental providers online at: . . . . . **myuhc.com/CommunityPlan**

NurseLine . . . . . **1-877-440-0255**, TTY **711**
Get 24/7 health advice from a nurse (toll-free)

Welcome to UnitedHealthcare Community Plan

We are glad to have you as a member. We look forward to serving your health care needs. UnitedHealthcare Community Plan is a managed care organization. That means all of the medical care and services members receive must be requested and provided by a doctor or health provider who is an AHCCCS registered provider.

UnitedHealthcare Community Plan is a contractor for the Arizona Long Term Care System (ALTCS).

This Member Handbook will help you find services, understand how managed care works, and provide you with valuable resources.

ALTCS

ALTCS is the same as Medicaid. It was created by the Arizona Health Care Cost Containment System Administration (AHCCCSA) to provide quality long-term care for eligible people in Arizona who cannot pay for certain health related services. This plan is available in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties.

Member Services

Member Services is here to help you with questions. They can:

- Answer questions about your physical and behavioral health benefits
- Help solve a problem or concern you might have with your doctor or any part of the health plan
- Help you find a doctor, dentist, behavioral health or other services
- Tell you about our doctors, their backgrounds, and the care facilities in our network
- Help you if you get a medical bill
- Tell you about community resources available to you
- Help you if you speak another language, are visually impaired, need interpreter services, or sign language services
- How to contact your Case Manager
- Help answer other questions you may have
- Provide you with a copy of the Member Handbook at no cost to you

Member Services is here to help you

Call 1-800-293-3740, TTY **711**, 8:00 a.m.–5:00 p.m., Arizona time, Monday–Friday, excluding state holidays.

After-hours: **1-800-377-2055**

When you call us ...

We ask questions to check your identity. We do this to protect your privacy. This is federal and state law. Gather the following information before you call:

- Member ID number
- Current address and phone number on file with AHCCCS
- Date of birth

Member Services is here to help you

Call **1-800-293-3740**, TTY **711**, 8:00 a.m.–5:00 p.m. Arizona time, Monday–Friday, excluding state holidays. After-hours **1-800-377-2055**.

NurseLine (available 24 hours per day/7 days a week) **1-877-440-0255**
TTY/TDD **711**

Visit our website – UHCCommunityPlan.com

It has resources and helpful information. For example:

- Information about UnitedHealthcare Community Plan
- Member Handbook and Member Newsletter
- Links to the AHCCCS website
- How to find a doctor, dentist, behavioral health, or other providers
- How to find a pharmacy
- How to find a prescription medication
- Links to health information
- Member education

Visit myuhc.com for personalized information

You can:

- View and print your member ID card
- Find a provider
- Manage your prescriptions
- View your benefits
- View claims and visits
- View your member handbook
- And much more!

Web Tech team

If you have any website or technical questions, please reach out to the Web Tech team. The Web Tech team ensures you have all that you need to take full advantage of available UHCCP services. You can receive assistance with: (please bullet)

- How to access our website
- How to navigate our website
- Updating your account settings
- Troubleshooting any issues you may have

The Web Tech team has experience assisting members and is here to help. For help, please call 1-877-542-9239 TTY 711, 8:00 a.m.–5:00 p.m., Monday–Friday.

UnitedHealthcare® mobile app

Get information on-the-go with the UnitedHealthcare mobile app. Download the UnitedHealthcare mobile app to your Apple® or Android® smartphone or tablet and see how easy it is to find nearby doctors, view the Member Handbook, find help and support in your community, or view your ID card.

Don't have the UnitedHealthcare® App yet?

Scan here to easily download the App

Assurance Wireless Lifeline Service

As a member, or as the guardian of a UnitedHealthcare member, you may qualify for Assurance Wireless a government Lifeline Assistance program that provides a mobile phone and service plan, at no cost. As an Assurance Wireless customer, you can easily access:

- Health-related information from UnitedHealthcare
- Benefit and program reminders via text for you and your family
- UnitedHealthcare Member Services

Already have Lifeline? You can switch from your current service provider.

Choose the Lifeline service that's right for you

Visit **AssuranceWireless.com/partner/buhc** to apply or learn more about Assurance Wireless Lifeline plans. Get ready to enjoy mobile health support at no cost to you.

What is a Case Manager and how to contact your Case Manager

A Case Manager is a person who helps you set up and schedule your care

You will get a Case Manager when you enroll. They will contact you within 7 business days of your enrollment.

Your Case Manager cannot give you medical care. You go to your doctor or a nurse for medical care. Your Case Manager will help set up services for you and send you for services. Your Case Manager will help you with any behavioral health, medical or social service needs. They will also help you to develop a Person-Centered Service Plan that is focused on your preferences and strengths to help you to meet your personal goals — this is called Member Empowerment.

Write your Case Manager's name and phone number on the inside cover of this handbook.

How to contact your Case Manager

Your Case Manager will provide you with their business card. Your Case Manager will review this information with you each time they visit you. Please call your Case Manager if you have any needs or questions between your Person-Centered Service Plan (PCSP) meetings with your Case Manager. If you do not have your Case Manager's telephone number, please call **1-800-293-3740**, TTY **711**. The call center representative will help you to contact your Case Manager.

Urgent and after-hours care

If you are sick, or have a sudden health problem, but it is not an emergency, call your PCP. Even if the office is closed, an answering service will take your call. Tell the answering service or the PCP what is wrong and listen to their instructions. They may send you to another doctor or tell you to go to an urgent care center that is contracted with UnitedHealthcare Community Plan. If you need help finding an urgent care center or you cannot contact your PCP, call Member Services at **1-800-293-3740**, TTY **711** or go to the UnitedHealthcare Community Plan website at **UHCCommunityPlan.com** to locate the nearest urgent care center.

If you are not sure your symptoms are life-threatening:

- Contact NurseLine at **1-877-440-0255** (TTY **711**) available 24 hours per day
- Call your PCP
- Call your Case Manager
- Contact DispatchHealth at 480-295-4490 for those in the Phoenix metropolitan area. Available daily, 8:00 a.m.–10:00 p.m.

Behavioral Health crisis services

What if I am experiencing a Behavioral Health Crisis?

If you are experiencing a behavioral health crisis, it is important to get help right away. For assistance with a mental health crisis please call or text **988**. Remember, you should always call **911** if you are experiencing a medical, police and/or fire emergency situation.

Crisis hotlines:

If you are experiencing a behavioral health crisis call one of the phone numbers below that matches the county you live in. Crisis hotlines are available 24 hours a day, 7 days a week, 365 days per year. Crisis calls are answered by a live trained crisis specialist. These crisis hotlines will provide access to 24/7 mobile crisis intervention and facility based 23-hour crisis stabilization centers, including detox/medication assisted treatment. Crisis services are available to all Arizonans and is not dependent on Medicaid status and health insurance coverage.

Single statewide crisis hotline . . . . . **1-844-534-HOPE (4673)** or **988**
You may also **text** . . . . . **4HOPE (44673)**
Chat – Start a chat now . . . . . **https://crisis.solari-inc.org/start-a-chat/**

Crisis hotlines by county:

	Phone
Gila, Maricopa Counties	**1-800-631-1314**
Apache, Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties	**1-866-495-6735**
Coconino, Mohave, Navajo and Yavapai Counties	**1-877-756-4090**
Gila River and Ak-Chin Indian Communities	**1-800-259-3449**
Salt River Pima Maricopa Indian Community	**1-855-331-6432**
Tohono O'Odham Nation	**1-844-423-8759**

Especially for teens:

Teen lifeline phone or text . . . **602-248-TEEN (8336)**

Senior Help Line: 24-hour senior help line . . . **602-264-4357**

National Suicide and Crisis Lifeline

Phone or text . . . **988**

Chat . . . **https://suicidepreventionlifeline.org/chat**

Online . . . **https://suicidepreventionlifeline.org**

National substance use and disorder issues

Referral and treatment hotline . . . **1-800-662-HELP (4357)**

Text . . . Text the word **"HOME"** to **741741**

Trans Lifeline:

A peer-support crisis hotline in which all operators are transgender . . . **1-877-565-8860**

Online . . . **www.translifeline.org**

Veterans crisis line/Beconnected line:

Veterans resources (and for those who support them) . . . **1-866-4AZ-VETS** or **1-866-429-8387**

Veteran's Crisis Line . . . **988**

Online . . . **BeconnectedAZ.org**

AHCCCS Opioid Service Locator . . . **https://opioidservicelocator.azahcccs.gov/**

National Maternal Mental Health Hotline | MCHB

24/7, no cost, confidential hotline for pregnant and new moms in English and Spanish.
Interpreter services are available in 60 languages (US only).
Call or text . . . . . **1-833-943-5746 (1-833-9-HELP4MOMS)**
TTY users can use a preferred relay service or . . . . . dial **711** and then **1-833-943-5746**
Not intended as an emergency response line.

Warm Line:

The Warm Line is a confidential telephone service staffed by peers who have, themselves, dealt with behavioral health challenges. Peer support specialists can relate to behavioral health situations because many have been through similar experiences. Peer support specialists offer peer support and compassion for callers who just need someone to talk with. This is available statewide at no cost. Members can call any number listed below:

Central Arizona
Solari Crisis & Human Services Network **602-347-1100**
24/7 (some hold time when at high volume)

Northern Arizona
NAZCARE **1-888-404-5530**
4:00 p.m.–10:30 p.m., Monday–Thursday
3:00 p.m.–10:30 p.m., Friday–Sunday
(recorded message asks for person's name and number and staff will return call)

Southern Arizona
HOPE, Inc:
Pima County **520-770-9909**
All other Southern AZ Counties **844-733-9912**
8:00 a.m.–10:00 p.m., 7 days a week
(recorded message: can hold or leave a voice message requesting call back)

A Family Warm Line supports family members that deal with behavioral health challenges. The support service provides confidential no cost guidance and connects people to resources for helping deal with job loss, heightened anxiety, and much more. Anyone who feels overwhelmed due to life's current challenges is encouraged to call.

Statewide in Arizona
Family Involvement Center (FIC) Warm Line **877-568-8468**
8:30 a.m.–5:00 p.m., Monday–Friday

Health equity, language, and cultural services

At UnitedHealthcare Community Plan, we celebrate people, ideas and experiences by creating a culture where all members are appreciated, valued, and able to contribute to their full potential. Deeply rooted disparities cannot be solved through a singular program or initiative. We see the opportunity to advance health equity in nearly every aspect of our ambition to help build a modern, high-performing health system that achieves better health outcomes.

UnitedHealthcare Community Plan has created health equity resources to help connect our members to the information they need and to promote better diversity, equity, and inclusion. Please visit the Resource section of our website at **UHCCommunityPlan.com**. Here you can explore the Community Resource Guide to find out about health information and community services for Behavioral Health, Housing, LGBTQ+ and more.

Clear communication is important to get the health care you need. UnitedHealthcare Community Plan provides member materials to you in a language or format that may be easier for you to understand. We also have interpreters for you to use if your doctor or service provider does not speak your language. If your doctor or service provider does not understand your cultural needs, we can help. We will work with your doctor or service provider or help you pick a new doctor or service provider.

English:

Call Member Services at **1-800-293-3740** for interpreter services, to find a doctor who understands your cultural needs, or for materials in another language or format. These services are provided at no cost to you.

Español:

Llame a Servicios para Miembros al **1-800-293-3740** para obtener servicios de interpretación, para encontrar a un doctor que entienda sus necesidades culturales o por materiales impresos en otro idioma o formato. Estos servicios son provistos gratuitamente.

Somali:

Adeegyada turjumaanka ka wac Adeegga Xubnaha lambarka **1-800-293-3740** , si aad u hesho dhakhtar fahmaya baahiyahaaga dhaqaneed, ama waxyaabo ku qoran luqad ama qaab kale. Adeegyadaas kuguma joogaan adiga wax kharash ah.

Simplified Chinese:
请致电会员服务部（电话： **1-800-293-3740** ）以获得口译服务、寻找了解您的文化需求的医生、或获得其他语言或格式的材料。上述服务均免费为您提供。

Serbian:

Pozovite Službu za usluge za članove na broj **1-800-293-3740** za usluge prevodioca, da pronađete lekara koji razume vaše kulturne potrebe ili za materijale na drugom jeziku ili u drugom formatu. Ove usluge vam se pružaju besplatno.

Traditional Chinese:
請致電會員服務部（電話： **1-800-293-3740** ）以獲得口譯服務、尋找瞭解您的文化需求的醫生、或獲得其他語言或格式的材料。上述服務均免費為您提供。

Romanian:

Sunaţi departamentul Servicii destinate membrilor la numărul **1-800-293-3740** pentru servicii de interpretariat, pentru a găsi un medic care înţelege necesităţile dvs. culturale sau pentru materiale în altă limbă sau în alt format. Aceste servicii vă sunt oferite gratuit.

Vietnamese:

Gọi Dịch Vụ Hội Viên theo số **1-800-293-3740** cho dịch vụ thông dịch, để tìm các bác sĩ hiểu rõ nhu cầu văn hóa của quý vị, hoặc các tài liệu bằng ngôn ngữ hoặc dạng khác. Các dịch vụ được cung cấp miễn phí cho quý vị.

Hungarian:

Hívja a tagsági szolgáltatásokat az **1-800-293-3740** -as számon tolmácsszolgáltatásokhoz, hogy egy olyan orvost találjon, aki megérti az Ön kulturális igényeit, illetve más nyelvű vagy formátumú anyagokért. Ezek a szolgáltatások az Ön számára ingyenesek.

Farsi:

برای برخورداری از خدمات ترجمه شفاهی، یافتن دکتری که نیاز های فرهنگی شما را درک کند، یا دریافت اطلاعات به زبان یا فرمت دیگر با شماره **1-800-293-3740** با قسمت خدمات اعضا تماس بگیرید. این خدمات بصورت مجانی در اختیار شما قرار می گیرد.

Swahili:

Pigia Huduma za Mwanachama katika nambari **1-800-293-3740** ili kupata huduma za mkalimani, kupata daktari anayeelewa mahitaji yako ya kitamaduni, au kwa nyenzo katika lugha au mfumo mwingine. Huduma hizi zinatolewa bila malipo yoyote kwako.

Albanian:

Telefonojuni shërbimeve për anëtarët në **1-800-293-3740** për shërbime interpretimi, për të gjetur një mjek që i kupton nevojat tuaja kulturore ose për materiale në gjuhë apo format tjetër. Këto shërbime ju sigurohen falas.

Arabic:

اتصل بقسم خدمات الأعضاء على الرقم **1-800-293-3740** لخدمات الترجمة الشفهية أو العثور على طبيب يتفهم احتياجاتك الثقافية أو طلب مواد بلغة أخرى أو بتنسيق آخر. تُقدَّم هذه الخدمات لك مجانًا.

If you require additional assistance to communicate, such as auxiliary aids, contact your Case Manager or Member Services. Auxiliary Aids are services or devices that help people with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the health plan. Auxiliary Aids may be provided at no cost to you, such as obtaining an audio reading of plan materials for the visually impaired. UnitedHealthcare Community Plan offers language and interpretation services in over 240 languages.

UnitedHealthcare Community Plan complies with all applicable federal and state laws, including:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, UnitedHealthcare Community Plan prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. UnitedHealthcare Community Plan must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity.

UnitedHealthcare Community Plan will provide sign language interpreters for people who are deaf and enlarged print materials.

It also means that UnitedHealthcare Community Plan will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible.

Visit our website or contact Member Services to obtain a copy of the UnitedHealthcare Community Plan Provider Directory at no cost to you. Our directory contains information about how our providers can meet your cultural, language, or accessibility needs. Members with high acuity illness or high service utilization can get assistance in navigating the provider network by calling Member Services at **1-800-293-3740**.

Members can also use the Provider Lookup feature online which is a provider search tool to find a doctor, hospital, other health care provider or facility. The tool allows you to search by specific categories. Members can follow this link directly to the Provider Lookup feature: **https://www.uhccommunityplan.com/az/medicaid/long-term-care.html**.

If you are directed to see a provider who is not contracted with UnitedHealthcare Community Plan, you will need to verify the provider is registered with AHCCCS, show the provider your ID card, and make sure the provider obtains an authorization for services to be performed. For services to be paid, the provider must be registered with AHCCCS and authorization must be obtained by the provider from us. For more information about this contact your PCP or call Member Services.

Members can receive a paper copy of the provider directory, at no cost, by contacting Member Services at **1-800-293-3740**, TTY **711**.

How managed care works

UnitedHealthcare Community Plan is a managed care plan. This means that all of the medical care and service you receive must be requested and provided by a doctor or health care provider that is in the UnitedHealthcare Community Plan network. You, your doctor and our Case Manager work together on a plan of care. One of the first steps is for our Case Manager to do an assessment with you. The Case Manager will then set up follow-up phone calls and home visits to meet your needs. You are responsible for working with your doctor, known as your PCP. A Primary Care Provider (PCP) is your doctor or Nurse Practitioner. They take care of your medical and clinical treatment. Your PCP may also refer you to a specialist. Your PCP works with you to manage your care. Talk to your PCP about all of your health care needs.

It is important that you have honest and straightforward communication with your PCP and follow your PCP's instructions. Your PCP will be able to identify the services that you need to keep you healthy.

ID card

When you join our plan, you will receive an ID card from UnitedHealthcare Community Plan. Your ID card is your key to getting health care services including behavioral health. It has your ID number, your name, and other important information. Your ID card identifies you as a UnitedHealthcare Community Plan member.

Your ID card has a phone number to access behavioral health and substance use services. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call the number on your card.

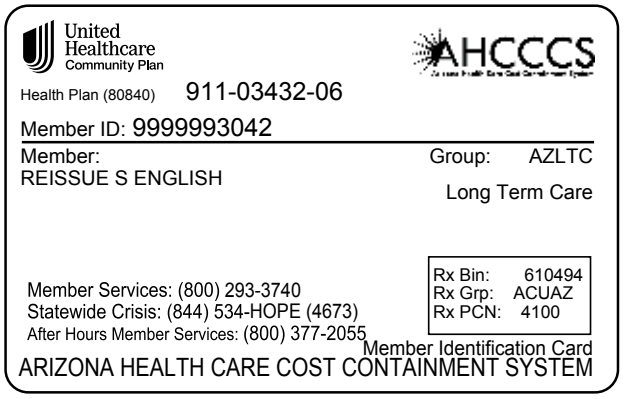
When you get your card, check it carefully. Call Member Services right away if any of the information on your card is wrong. Member Services can be reached by calling **1-800-293-3740**, TTY **711**.

Quick tips

- Your ID card is for your use only. Don't let others use it.
- Carry your ID card at all times and keep it in a safe place
- Do not lose your card or throw it away
- You will need your card when you get medical care or when you pick up medicine at the pharmacy
- Misusing your medical ID number, like loaning or selling the card or the information on it, is against the law
- Misusing your card or medical ID number may result in legal actions and you could lose your AHCCCS eligibility, benefits and health care services
- If you notice others getting benefits they are not eligible for or someone misusing the medical ID card, please tell us right away. You can call or write AHCCCS or UnitedHealthcare Community Plan Member Services. AHCCCS also has a Member Fraud Hotline you can call at 1-888-ITS NOT OK (1-888-487-6686) or 602-417-4193 or email **AHCCCSFraud@azahcccs.gov**.
- You may also call AHCCCS or UnitedHealthcare Community Plan to report any provider you believe may be giving services to members that are not needed or should not be given
- If you have an Arizona driver's license or state issued ID, AHCCCS will obtain your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). The AHCCCS eligibility verification screen viewed by providers contains your picture (if available) and coverage details.

Do not throw away your ID card.

Sample card


United Healthcare Community Plan

AHCCCS

Health Plan (80840) 911-03432-06

Member ID: 9999993042

Member:
REISSUE S ENGLISH

Group: AZLTC
Long Term Care

Member Services: (800) 293-3740
Statewide Crisis: (844) 534-HOPE (4673)
After Hours Member Services: (800) 377-2055

Rx Bin: 610494
Rx Grp: ACUAZ
Rx PCN: 4100

Member Identification Card
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM


Printed: 10/13/20

Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit myUHC.com/CommunityPlan.

Member Services: 1-800-293-3740 TTY\TDD 711
NurseLine: 1-877-440-0255

For Providers: UHCprovider.com
Claims: PO Box 5290, Kingston, NY, 12402-5290
Notification: 1-800-377-2055 Eligibility: 1-800-293-3740

Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

Front

Back

Member responsibilities

You have the responsibility to:

Use services

- Ask questions if you do not understand your rights or plan of treatment
- Keep your appointments
- Cancel appointments in advance when you cannot keep them
- Contact your PCP first for non-emergency medical needs
- Understand when you should and should not go to an emergency room
- Know whom to call if you need a ride to the doctor or for other covered services
- Treat providers and health plan staff with respect and dignity
- Be in charge of your planning meeting
- Ask anyone you want to come to your planning meetings
- Choose your goals to work on and what is in your plan
- Schedule your person-centered planning meeting at a time and place when the people who you want to attend are available
- Follow your doctor's instructions and treatment plan for care that you have agreed to, and tell your doctor if their explanations are not clear
- Agree to the services you want from the choice of services you can have
- Pick an available provider you want to receive services from
- Know that you may need help from your guardian, family and/or friends to make good choices

Give information

- Tell your PCP and Case Manager about your health and changes in your health
- Supply information that your plan, practitioners, or families need in order to provide your care
- Tell Member Services and/or your Case Manager about changes in your Medicare, Medicare HMO or private insurance. This includes adding or ending other insurance.
- Talk to your providers and your Case Manager about your health care. Ask questions about the ways your health problems can be treated.
- Notify your Case Manager and AHCCCS if your family size changes, if you move or if your income changes

"Healthier lives. Healthier you."

- Work as a team with your PCP and Case Manager to decide what care is best for you
- Understand how what you do can affect your health
- Understand your health problems and participate in developing mutually agreed-upon treatment goals
- Do the best you can to stay healthy
- Treat providers and staff with respect. Which includes, refraining from use of disparaging remarks, racial or ethnic slurs, profanity towards providers, caregivers and/or Case Managers are not acceptable.

Not to ask your Case Manager to:

- Provide hands on care
- Move any of your belongings
- Drive you in their car
- Lend you money
- Sign forms or paperwork for you

In the presence of your Case Manager you cannot: use drugs, drink alcohol, display firearms, make sexual advances or disrobe.

Moving out of the county, state, or country

Call your Case Manager before you move to another county, state, or country.

If you move to a county that is NOT served by UnitedHealthcare Community Plan Long Term Care, you will need to change your health plan. Your change needs to be communicated to your Case Manager in writing or verbally. UnitedHealthcare Community Plan will send the request to the new health plan in that area.

If you move out of the state or country, you must sign a disenrollment form. No services are available outside of the United States. This form says you will no longer be a member in the ALTCS program and UnitedHealthcare Community Plan. Contact your Case Manager for more information.

What care is available outside my service area?

If you are briefly away from Arizona or out of your county of residence, report your absence or trip to your Case Manager. When you are outside your service area, for example, out of Arizona, UnitedHealthcare Community Plan only pays for emergency care. If you have an emergency, go to the nearest emergency room or hospital. Tell them you are a member of UnitedHealthcare Community Plan or show your ID Card. Any service you get that is not an emergency will not be covered by UnitedHealthcare Community Plan. You may be charged for services that are not an emergency. If you need care, but it is not an emergency, call your PCP or Member Services. UnitedHealthcare Community Plan will not pay for any services received outside of the country including emergency care.

Changes in information

Changes you must report to your Case Manager include:

- Adoption
- Marriage
- Birth
- Moving to a new county
- Death
- Divorce
- Moving to a new state
- Guardianship
- Address
- Phone number
- Insurance changes
- Income changes

Changing plans

Every year if you reside in Maricopa, Pinal or Gila counties, you have the option to change plans during Annual Enrollment Choice (AEC). This is the date you enrolled with AHCCCS. AHCCCS will send you a notice two months before the date you can change. If you experienced concerns with your health care delivery, we want to help resolve those issues, call UnitedHealthcare Community Plan Member Services. Otherwise, if you want to change health plans, follow the instructions in the letter received from AHCCCS.

If you want to change health plans and it is not your AEC period, you may still be able to change plans in special cases. You may be able to change your health plan if:

- Medical continuity of care.* Your continuity of care when changing plans is very important. It is a process that involves you, your PCP, your Case Manager and all members of your health care team.
- If you get information about available providers that is not correct*
- If you were not given a choice by ALTCS when you enrolled*
- During annual open enrollment*

- If you and a family member are with different Plans*
- If we end a contract with the facility/setting in which you live*
- If you move to a county where we are not the ALTCS provider, then your Case Manager will ask for the Plan change on your behalf. They will ask that the ALTCS provider for that county accept you.
- If you lost ALTCS eligibility and were disenrolled, then later reapproved for ALTCS eligibility within 90 days of the disenrollment date, but you were enrolled with a different plan

***Applies only if you reside in Maricopa, Pinal and Gila counties.**

Contact your Case Manager to ask for a program contractor change request if you desire to change plans.

If your plan change request is denied, you will receive a denial letter. If you do not agree with the decision you may file a grievance. Information on how to file a grievance will be included in the denial letter. You may call Member Services at any time to help with this process.

ALTCS transitional program

A transitional program is for members who do not meet nursing home level of care according to ALTCS eligibility requirements, but may need other long term care services. ALTCS Transitional members whose condition briefly gets worse may get up to 90 continuous days of medically necessary nursing home care at a time. Transitional Program members can receive services in their home or in an assisted living facility including physical and behavioral health services and/or Transitional Program members are eligible to receive other medically necessary ALTCS services.

Even if nursing home care is not medically needed, a short-term stay up to 25 days per year (October 1–September 30) may be possible using your respite benefit which is an ALTCS home and community-based service.

The transitional program applies only to existing members, not newly enrolled members.

Transition of care if you change plans

If you change plans by moving from a Fee For Service (FFS) plan to a Managed Care Organization (MCO), an MCO to a different MCO, or an MCO to a FFS plan for any reason, your current health plan and new health plan will work together to make sure you have no delay in services and have continued access to care in services.

Treatment planning

A treatment plan is a written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and updated by the multi-specialty, interdisciplinary team.

A service plan is a written description of all covered health services and other supports which may include goals, family support services, care coordination, and plans to help the member in achieving an improved quality of life.

Case Management assesses, plans, coordinates, and monitors options and services to meet the health needs of the member through communication and available resources to promote quality and cost-effective outcomes. It includes a review of the member's strengths and needs by the member, his/her family health care decision maker, or designated representative with the Case Manager so they can make informed decisions. Case management respects the preferences, interests, needs, culture, language and belief system of the member and his/her family/health care decision maker, or designated representative. The Case Manager ensures the member and family/health care decision maker, or designated representative are partners in the treatment planning process and development of the person centered service plan. This partnership is expected to result in a mutually agreed upon service plan that meets the medical, functional, social and behavioral health needs of the member.

Emergency care

An emergency is a sickness that is sudden and puts your life in danger or can cause harm to you if not treated right away. In an emergency, it is very important to get care right away. If you have an emergency, call 911 or go to the nearest emergency room. You have the right to go to any hospital emergency room or other setting for emergency services, such as an urgent care center when your doctor's office is closed. Not all health problems are an emergency. Some reasons to call 911 or go to the emergency room include:

- Sudden loss of feeling, or not being able to move
- Chest pain
- Severe pain in your stomach area
- Poisoning
- A serious accident
- Severe shortness of breath
- Severe burns
- Severe wound or heavy bleeding
- Damage to your eyes
- Severe spasms/convulsions
- Broken bones
- Choking or being unable to breathe
- Throwing up (vomiting) blood
- Strong feeling that you might hurt yourself or another person
- Faint or pass out for no reason (will not wake up)
- Danger of losing life or limb
- Loss of speech
- Assault

If you are not sure it's a real emergency, call your PCP. If you do go to an emergency room, call your PCP as soon as you can after your visit so you can get the right care. Prior authorization is not required for emergency care.

If you have questions about whether your situation requires treatment in an urgent care center or an emergency room, call your PCP or NurseLine at 1-877-440-0255, TTY/TDD 711. NurseLine is available 24 hours per day/7 days a week.

If you do go to an emergency room, show ALL ID cards when you arrive. Call your PCP and Case Manager within 2 days/48 hours, or as soon as possible. Any follow-up care will be given by your PCP. You should see your PCP within 7 days after you leave the hospital.

If you get emergency services, ask the hospital or doctor to send your records to your PCP. Call UnitedHealthcare Community Plan if you get emergency services. If you go to an emergency room, tell them:

- You are on ALTCS
- Your health plan is UnitedHealthcare Community Plan
- To send your medical records to your PCP

If you cannot do this yourself, have a friend or family member do this.

When not to use the emergency room

Most sicknesses are not emergencies and can be treated at your doctor's office. You can also be treated at an Urgent Care site. You should not use an emergency room if you have one of these minor problems:

- A sprain or strain
- A cut or scrape
- An earache
- A sore throat
- A cough or cold

Non-emergent hospital services

Non-emergent hospital services are covered when arranged by an in-network physician at a participating facility. Your in-network physician will make these arrangements if medically necessary.

Emergency transportation

Emergency care and transport is available 24 hours a day, 7 days a week. Call **9-1-1** or your local emergency number.

As soon as you are able, **call your PCP and your Case Manager**. If you cannot call, have a friend or family member call. If you live in a nursing or an assisted living facility, let staff know. They will arrange for emergency care and transport for you.

Non-emergency transportation

If you need a ride to an appointment, ask a friend, family member or neighbor first. If you cannot get a ride, UnitedHealthcare Community Plan will help you. Members may receive non-emergency transportation services through UnitedHealthcare Community Plan for AHCCCS covered services. You are responsible for setting up your own transportation. Members and/or family health care decision maker, or designated representatives are able to schedule non-emergency transportation. There is no additional authorization necessary.

Following these simple rules will help you get a ride:

- Call at least 72 hours before your health care visit
- Call **1-888-700-6822** or **602-889-1777**, TTY/TDD **711** to set up your ride
- If you cancel your visit, call **1-888-700-6822** or **602-889-1777** to cancel your ride
- Rides are only for covered services
- Know the address of your health care provider
- Be specific about where you need a ride to
- After your visit, call for a ride home
- Let us know if you have special needs like using a wheelchair for mobility, or needing escort assistance to go with you to or from your final destination
- Members 14 years of age and younger must have a parent or guardian with them. Members between the ages of 15 and 17 must be accompanied by a parent or guardian unless Medical Transportation Brokerage of Arizona (MTBA) has received a signed waiver of consent from the member's parent or guardian.
- Transportation may be limited to a provider near you

If you need transportation to an urgent care center, you may call at any time, any day of the week. You do not need to give advance notice for urgent care transportation.

If you have a life-threatening emergency, call 911. Non-emergent transportation is not for emergencies.

Covered health care services

These are many of the Long Term Care covered services you can receive if they are **medically necessary**. Medically necessary means covered services provided by a qualified doctor within the scope of their practice to prevent disease, disability, and other health conditions or their progression to prolong life. Your PCP or primary specialist will help you decide if you need a covered service. If you receive services that are not covered by Long Term Care, you may be required to pay for them.

UnitedHealthcare reviews new procedures, devices, and drugs to decide if they are safe and effective for members. If they are found to be safe and effective, they may become covered. If new technology becomes a covered service, it will follow plan rules, including medical necessity.

Covered service
Adaptive aids
Allergy testing (limitations for members 21 years of age and older)
Ambulatory surgery
Bariatric surgery
Behavioral health residential facilities (BHRF)
Behavioral health services
Breast reconstruction after a mastectomy
Chiropractic services • Chiropractic services are covered for members under 21 years of age when prescribed by the member's Primary Care Provider • Chiropractic services are covered for adults when ordered by a Primary Care Provider. The adult maximum benefit is 20 chiropractic visits per year. • Additional chiropractic services are available if medically necessary with prior authorization
Clinical trials (covered under certain criteria. Must be pre-authorized.)
Cochlear implants for members under the age of 21

Covered service
Dental care — Routine, preventive, and therapeutic dental adult benefits for members who are 21 years of age and older. Dental services are limited to a total amount of $1,000 for each 12-month period beginning October 1 through September 30 each year. Covered services include dentures, and preventive dental care (checkups, cleaning, X-rays if needed, fluoride treatments). You may also have benefits to fix your teeth like fillings, root canals, simple extractions, crowns, or other dental work. If you need major dental work, your dentist may have to check with the plan first to make sure it will all be covered. The dental limit for American Indian and Alaskan Native members when receiving dental services at an IHS/638 Facility has been removed. Services performed outside of the IHS/638 tribal facilities remain limited to the $1,000 emergency dental benefit for members 21 years of age and over, and the additional $1,000 for dental services for Long Term Care members.
Dental care — Emergency dental services for members 21 years of age and older. Services are limited to a total amount of $1,000 for each 12-month period beginning October 1 through September 30 each year. Limited medical and surgical services by a dentist for members 21 years of age and older.
Dental care — Routine and emergency dental care for members under the age of 21
Diabetic services, supplies, and self management trainings for adults and children. This includes up to 10 program hours annually of diabetes outpatient self-management training services if prescribed by a PCP in specified circumstances.
Dialysis services
Doctor services
Durable medical equipment and supplies
Emergency services, 24-hour emergency care, emergency transport, and emergency room. (Emergency service does not require a prior authorization.)
Family planning services and supplies for both women and men. This includes birth control pills, supplies and devices; surgical procedures to cause sterility (inability to reproduce), delay or prevent pregnancy.
Genetic/biomarker testing and counseling when considered medically necessary

Covered service
Gynecology. Female members have direct access to a gynecologist within the Contractor's network without a referral from a primary care provider. Preventive services such as cervical cancer screening or referral for a mammogram are covered.
Hearing exams to evaluate medically necessary hearing loss, both inpatient and outpatient
Hospital inpatient or outpatient
Hospital observation
Human Immunodeficiency Virus (HIV) testing, counseling, and treatment
Hysterectomy (medically necessary)
Incontinence briefs — are covered for members when needed to treat a medical condition like a rash or infection. These briefs are also called adult diapers and pull-ups. Prior approval may be needed. Briefs are also covered to avoid or prevent skin breakdown for **members in the ALTCS program who are 21 years of age and older when**: • You have a medical condition which causes incontinence. This is when the body is not able to control going to the bathroom, and • The doctor gives you a prescription for the briefs, and • No more than 180 briefs are needed in a month, unless the doctor shows that more than 180 briefs in a month are needed, and • You get the briefs from the Health Plan's providers, and • The doctor has gotten any needed approval from the Health Plan. For members over the age of three and under 21 years, incontinence briefs shall not exceed more than 240 per month unless when deemed medically necessary.
Lab, X-rays, and medical imaging
Lung volume reduction surgery (LVRS): LVRS, or reductive pneumoplasty is covered for persons with severe emphysema, covered when medically necessary
Maternity services, including prenatal care, labor and delivery, and postnatal care. Female members may have direct access to OB/GYN providers in the network without a referral.
Metabolic medical foods

Covered service
Orthotic devices — Orthotics are devices that help a weak or deformed part of the body • For members under the age of 21, orthotics are covered when prescribed by the member's Primary Care Provider, attending physician, or specialist • For members age 21 and older, orthotic devices are covered when: – The orthotic is medically necessary as the preferred treatment based on Medicare Guidelines, **and** – The orthotic costs less than all other treatments for the same condition, **and** – The orthotic is ordered by a doctor or Primary Care Practitioner (a nurse practitioner or physician assistant).
Pharmacy services. Members must get drugs from the UnitedHealthcare Community Plan Formulary. This is a list of medicines that UnitedHealthcare Community Plan will provide. Go to **https://www.uhccommunityplan.com/az/medicaid/long-term-care.html** to view it. Or call your Case Manager. Coverage may include certain Part D excluded drugs, if you are in a Medicare Part D Plan (PDP).
Podiatry services, AHCCCS covers medically necessary foot and ankle care, including reconstructive surgeries, provided by a licensed podiatrist or other qualified licensed practitioner or physician
Preventive services including, but not limited to, screening services such as cervical cancer screening including Pap smear (annually for sexually active women), mammograms (annually after age 40 and at any age if considered medically necessary), colorectal cancer, and screening for sexually transmitted infections
Private duty nurse, if medically necessary
Prosthetic devices when medically necessary
Respiratory therapy
Services in a Rural Health Clinic or Federally Qualified Health Center
Substance abuse transitional facilities
Telehealth visits over the phone or video
Transplantation of organs and tissue and related medications covered for members with specified medical conditions • Transplant services and medications when medically necessary, must be pre-authorized • Transplants must be done at an AHCCCS approved transplant center

Covered service
Vision — For members who are 21 years of age and older, emergency care for eye conditions which meet the definition of an emergency medical condition. In addition cataract removal, and medically necessary vision examinations, prescriptive lenses and frames are covered if required following cataract removal.
Vision — For members under the age of 21, routine and emergency eyecare and all necessary vision examinations, prescriptive lenses, frames (including replacement and repair of broken or lost eyeglasses without restriction), and treatments for conditions of the eye.
Vision — Treatment of medical conditions of the eye, excluding eye exams for glasses or contact lenses and the glasses or contact lenses, except after cataract surgery, for members who are age 21 or older
Well visits (well exams) are covered for members. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling, and medically necessary immunizations. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visits for members under 21 years of age are considered the same as a well visit.
Therapies covered for members who are 21 years of age and older
Occupational therapy inpatient/outpatient Covered when medically necessary
Physical therapy inpatient Covered when medically necessary
Physical therapy outpatient • 15 visits per benefit year (October 1–September 30) to restore a skill or function the member had but lost due to injury or disease and maintain that function once restored; and • 15 visits per benefit year (October 1–September 30) to reach or obtain a skill or function never learned or developed and maintain that function once developed.
Speech therapy inpatient/outpatient Covered when medically necessary

Covered Home and Community-Based Services (HCBS) may include:

- Adult day health care
- Home-delivered meals
- Home health agency including nursing services and licensed home health aide services
- Emergency alert system
- Homemaker services
- Hospice
- Palliative care
- Personal care and licensed health aide services
- Private duty nursing
- Respite care. Respite care is a temporary break for persons providing care to our members. Respite must be pre-approved and authorized by the Case Manager. Up to 600 respite hours per benefit year (October 1–September 30) are available.
- Group respite as alternative to adult day health
- Attendant care models of care
  - Parents may provide attendant care services if the member is 18 years of age or older. Contact your Case Manager for more information.
  - Agency with choice — Allows you to make decisions about the attendant and the schedule you want. Contact your Case Manager for more information.
  - Spouses as paid caregivers authorized by the Case Manager. Contact your Case Manager for more information.
  - Self-directed attendant care — Allows you to act as the employer and can hire, train or dismiss the attendant of your choosing. Contact your Case Manager for more information.
  - Traditional attendant care — Allows you to select an attendant from network of attendant care providers. Contact your Case Manager for more information.
- Medically necessary home modifications
- Supported employment for individual or group
- Durable Medical Equipment (DME) — Standard and custom DME

Non-covered health care services

These are not covered:

- Services from a provider who is not registered with AHCCCS
- Services that are not medically necessary
- Services given without authorization by a provider who is not with UnitedHealthcare Community Plan
- Services that will not help you get better. (Services that are not medically necessary.)
- Services that are determined to be experimental by the health plan Medical Director
- Services that are not the least costly service with the same result
- Sex change/gender reassignment operations
- Reversal of self-requested sterility (typically the inability to reproduce)
- Care not covered under AHCCCS and ALTCS rules or policies
- Man-made (artificial) hearts or xenografts (taking and transferring tissue from another species/animal)
- Organ transplants not included in AHCCCS rules or policies
- Services in a place not Medicare/Medicaid certified for such services
- Room and board in assisted living facilities and behavioral health group homes
- Medical Marijuana — AHCCCS does not cover medical marijuana as a medical or pharmacy benefit
- Medical services for those in an institution for TB (tuberculosis) treatment
- Over-the-counter medicines and medical supplies (except under certain conditions). Refer to the UnitedHealthcare Over-the Counter Drug List for a list of products available on our website at: **UHCCommunityPlan.com** or call Member Services to request a printed copy.
- Personal care items such as combs, razors, soap, etc.
- Prescriptions not on our list of covered medications, unless approved
- Routine eye examinations for prescriptive lenses or glasses for adults 21 and over
- Allergy Immunotherapy not covered for ages 21 and over

The following are not covered for the purpose of family planning services:

- Infertility services including diagnostic testing, treatment services or reversal of surgical infertility
- Pregnancy termination counseling

In addition, the following services are not covered, or only limited amounts are covered, for adults 21 years and older:

Benefit/Service	Service description	Service excluded from payment
Bone-Anchored Hearing Aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing Aid (BAHA). Supplies, equipment maintenance (care of the hearing aid) and repair of any parts will be paid for.
Cochlear Implant	A small device that is put in a person's ear by surgery to help you hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower Limb Microprocessor Controlled Joint/Prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Transplants	A transplant is when an organ or blood cells are moved from one person to another.	Approval is based on the medical need and if the transplant is on the "covered" list. Only transplants listed by AHCCCS as covered will be paid for.

Prior period coverage

You may be eligible for Prior Period Coverage (PPC). PPC is for some members with long term home and community-based services (HCBS), nursing home, or assisted living services in place from when the member applied for ALTCS to when the member became eligible for ALTCS.

During PPC, health care services are looked at by the Case Manager. The Case Manager will see if UnitedHealthcare Community Plan is permitted to pay the provider.

The services must meet three areas to qualify for UnitedHealthcare Community Plan payment:

1. Medically necessary.
2. Cost-effective.
3. Provided by an AHCCCS-registered health care provider.

Covered Long Term Care Services – Institutional

Certain covered long term care services may include:

- Nursing home (including Christian Science). If you are living in a nursing home, you pay your "share of cost" to the home. ALTCS will tell you your "member share of cost."
- Institution for mental disease (IMD)
- Psychiatric residential treatment center for age 21 years and under

Covered Home and Community-Based Services (HCBS)

Covered HCBS alternative residential settings may include:

- Assisted living home. (ALTCS approved with rooms for 10 or fewer residents.)
- Assisted living centers. (A setting that provides resident rooms or residential units and services to 11 or more residents.)
- Adult foster care. (ALTCS HCBS approved with services on a continuing basis for four or fewer people.)
- Behavioral Health residential facility
- If you are in an assisted living setting, you must pay for your room and board. You pay this directly to your facility.

Accessing Non-Title XIX/XXI services

Non-Title XIX/XXI services, based on the availability of funding. For more information on how to access these services contact your Case Manager. Non-Title XIX/XXI services include:

- Supported housing services to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartment and homes owned or leased by a subcontracted provider. These services include rent and/or utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.
- Auricular acupuncture that is medically and clinically necessary. To be performed by a certified acupuncturist practitioner of auricular acupuncture needles to treat alcoholism, substance use or chemical dependency.
- Childcare supportive services are covered when providing medically necessary Medicated Assisted Treatment or outpatient (non-residential) treatment or other supportive services for SUD to Members with dependent children, when the family is being treated as a whole
- Mental health services (previously known as Traditional Healing Treatment) for mental health or substance use problems provided by qualified traditional healers. These services include the use of techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.
- Mental Health Services, Room and Board. Lodging and meals to an individual residing in a residential facility or supported independent living setting which may include but is not limited to:
  a. Housing costs,
  b. Services such as food and food preparation,
  c. Personal laundry, and
  d. Housekeeping.
- Examples of other services include, but not limited to:
  a. Medication
  b. Counseling
  c. Case management
  d. Crisis services, and
  e. Support services

These services are available to members through a referral to the Regional Behavioral Health Authority (RBHA) located in the member's county. Members can access Non-Title XIX/XXI services, by calling their Case Manager or Member Services. A request will then be sent to our Behavioral Health Coordinators for both general mental health, Serious Emotional Disturbance (SED), and SMI. The Behavioral Health Coordinators work directly with the designated RBHA Liaison to set-up the needed services and will outreach the member directly to help coordinate care.

Housing services

Your Case Manager can assist you in finding local low-income housing options that are available utilizing our Program Housing Coordinator or make a referral to the AHCCCS Housing Program, if eligible. Members can obtain information about housing services and referrals by contacting their Case Manager or Member Services at **1-800-293-3740**, TTY **711**.

Members are assessed for their health care needs and social determinants of health by their PCP, behavioral health provider, or Case Manager. Member's assessment may indicate a housing need. Supported housing services are designed to assist individuals or families to obtain and maintain housing in various settings depending on member need, with emphasis on independent community settings including the person's own home or apartments. Members can obtain basic information about affordable housing and shelters in the links below.

In addition to the housing resources available in the community, AHCCCS oversees several permanent supportive housing programs throughout Arizona. The AHCCCS Housing Program supports members with a designation of Serious Mental Illness (SMI) and some services are provided for members with a General Mental Health and/or Substance Use Disorder (GMHSUD). Contact your Case Manager or Behavioral Health provider to determine if you are eligible for a referral to the AHCCCS Housing Program. These referrals can be made by your provider or Case Manager as part of an individual service plan, based on medical necessity. For more information visit: **www.azabc.org/ahp/**.

How can someone experiencing homelessness obtain services?

Any member experiencing homelessness should contact their Case Manager and a coordinated entry site to be assessed for available housing interventions. Coordinated entry is a process for assessing all people experiencing homelessness in their region to identify their vulnerability levels and prioritize persons who are most in need of assistance for available housing and services.

Listed below are the Coordinated Entry Access Points in Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties. Housing interventions are determined by the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT). The tool is designed to be quick and effective. The VI-SPDAT usually takes less than 10 minutes and is used to determine what intervention would be most useful to the person/family experiencing homelessness. Coordinated entry can get members connected to shelters and also help with additional housing interventions if the member is eligible. For more information contact your Case Manager.

Coordinated Entry Access Points for members who report as homeless

Refer members experiencing homelessness or risk of homelessness to the HEARTH Continuum of Care (CoC) program through the local Coordinated Entry system in their community. The following links give more information about the services available in each region.

- Arizona Balance of State CoC The Arizona Department of Housing serves as the Collaborative Applicant and Homeless Management Information System (HMIS) lead agency for the CoC for the 13 non-metro counties in the state, including Apache, Coconino, Gila, and Mohave, Navajo, Pinal, and Yavapai. Locate community access points by county by visiting: **https://housing.az.gov/general-public/homeless-assistance**.
- Phoenix/Mesa/Maricopa County Regional CoC is staffed by the Maricopa Association of Governments. More than 40 homeless assistance programs in 13 different agencies are supported. Locate community access points by visiting: **https://maricopahousing.org/wp-content/uploads/2021/07/Coordinated-Entry-Points-Handout.pdf**.

Housing resources:

Arizona Department of Housing **602-771-1000**

Income-based housing:

- Subsidized apartment search:
  https://resources.hud.gov/ Subsidized apartment search
- Public Housing Authorities:
  https://www.hud.gov/program_offices/public_indian_housing/pha/contacts
- Housing Choice Vouchers (Section 8):
  https://www.hud.gov/topics/housing_choice_voucher_program_section_8
- Section 202 Supportive Housing for the Elderly:
  https://www.hud.gov/program_offices/housing/mfh/grants/section202ptl
- Section 811 Supportive Housing for Persons with Disabilities:
  https://www.hud.gov/program_offices/housing/mfh/grants/section811ptl

Sober living housing:

- AZ Recovery Housing Association Certified Sober Living Communities
  https://myazrha.org/landing/

Eviction prevention resources:

- Emergency Rental Assistance: **https://www.consumerfinance.gov/coronavirus/mortgage-and-housing-assistance/renter-protections/find-help-with-rent-and-utilities/**
- HUD Approved Housing Counseling Agencies: **https://apps.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&webListAction=search&searchstate=AZ**

Department of Housing & Urban Development subsidized apartment search tool:

- **https://resources.hud.gov/**

To receive additional information regarding these programs, contact your Case Manager.

There are Non-Title XIX/XXI services available based on funding, for: Supported housing services to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes owned or leased by a subcontracted provider. These services include rent and/or utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.

Employment services

Did you know....?

Working may be an important part of a person's recovery as it gives structure and routine while boosting self-esteem and improving financial independence. Even if you are collecting public benefits, like Social Security, you may be able to make more money and still keep your medical benefits. For people with intellectual and/or developmental disabilities, Vocational Rehabilitation is an important resource to help you reach your job goals.

AHCCCS employment services

You may have access to employment and rehabilitation services through your behavioral or integrated health home. This includes both pre- and post-employment services to help you get and keep a job. Some examples of the employment services you may be eligible for include:

- Career/educational counseling
- Benefits planning and education
- Connection to Vocational Rehabilitation and/or community resources
- Job skills training
- Résumé preparation/job interview skills

- Assistance in finding a job
- Job support (job coaching)

To learn more about employment services and supports, or to get connected, ask within your behavioral or integrated health home, your Case Manager, or contact Member Services at **1-800-293-3740**, TTY **711**.

How to connect to employment services

All areas of the state have dedicated employment specialists ready to assist you, your Case Manager, and your planning team with employment resources. Your Case Manager can connect you with employment services and supports that meet your needs and will work with you to determine the best services necessary based on your job goal. Speak with your Case Manager for more information about getting connected with employment services. If you have any questions, you may also call Member Services who will connect you to UHCCP's Employment Administrator.

Other employment resources

Vocational Rehabilitation (VR)

VR is a program within the Arizona Department of Economic Security (ADES) designed to assist eligible individuals who have disabilities prepare for, get, and keep a job. You may be eligible for VR services if you meet the following requirements:

- You have a physical or mental disability
- Your physical or mental disability results in a significant barrier to employment
- You require VR services in order to prepare for, get, keep, or regain employment
- You can benefit from VR services in terms of achieving an employment outcome

Once you apply for the VR program and are determined eligible, you will work with the VR Counselor to develop a plan for employment. Plan development includes identifying a competitive employment goal and will address any disability-related barriers to employment. Ask your behavioral or integrated health home about a referral to VR or contact a local VR office directly. Ask your Case Manager about a referral to VR.

For more information and to locate the nearest VR office to you, visit **https://des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation-vr**.

ARIZONA@WORK

This statewide job center offers a wide array of workforce services at no cost to connect Arizona job seekers to gainful employment. Through ARIZONA@WORK, you can connect with local employers who have immediate job openings on Arizona's largest employment database, the Arizona Job Connection website. ARIZONA@WORK can connect you to their partners for expert advice and guidance on everything from childcare, basic needs, Vocational Rehabilitation for job seekers with disabilities, and educational opportunities.

For more information and to locate the nearest ARIZONA@WORK office, visit **https://arizonaatwork.com/**.

Residential placement

Institutional placements

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

Nursing Facility, including Religious Nonmedical Health Care Institutions: The nursing facility must be licensed and Medicare/Medicaid certified by ADHS to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician.

Behavioral Health Inpatient Facility: A health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

1. Have a limited or reduced ability to meet the individual's basic physical needs,
2. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality,
3. Be a danger to self,
4. Be a danger to others,
5. Be a person with a persistent or acute disability, or
6. Be a person with a grave disability.

Alternative HCBS placements

Assisted Living Facility: An Assisted Living Facility (ALF) is a residential care institution that provides supervisory care services, personal care services or directed care services on a continuing basis. All approved residential settings in this category are required to meet ADHS licensing criteria. All settings must be integrated in and support access to the greater community. Covered settings include:

Adult Foster Care Home: An Alternative HCBS Setting that provides room and board, supervision and coordination of necessary adult foster care services within a family type environment for at least one and no more than four adult residents who are ALTCS members.

Assisted Living Home: An Alternative HCBS Setting that provides room and board, supervision and coordination of necessary services to 10 or fewer residents.

Assisted Living Center: An Alternative HCBS Setting, that provides room and board, supervision and coordination of necessary services to more than 11 residents.

Adult Behavioral Health Therapeutic Home: Licensed by Arizona Department of Health Services (ADHS). A behavioral health supportive home that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to Case Manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issues and need for behavioral health services.

Behavioral Health Respite Homes: Licensed by Arizona Department of Health Services (ADHS) as a behavioral health residential facility that is qualified to provide respite services.

End of Life Care

End of Life (EOL) care is a member-centered approach with the goal of preserving member rights and maintaining member dignity while receiving any other medically necessary covered services, while providing relief of stress, pain, or life limiting effects of illness to improve the quality of life. EOL care includes providing you and your family with information about your illness and treatment choices. EOL care allows you to receive Advance Care Planning, palliative care, supportive care and practical care services. Members who receive EOL care can choose to receive curative care until they choose to receive hospice care.

Seeing a specialist or other providers

A specialist is a health care provider who cares for a certain area of the body. Your PCP is in charge of all your covered health care needs. If you need specialty care, your PCP may refer you to a specialist or another doctor. Members and members with special health care needs may also request services without a referral or prior authorization and may choose a provider from UnitedHealthcare Community plan's provider network. For urgent specialty care appointments member will be seen no later than 2 business days from the request and routine care appointments are within 45 calendar days of the request.

If your PCP wants you to see a specialist who is not contracted with UnitedHealthcare Community Plan:

- The specialist must be registered with AHCCCS
- Your PCP must get approval from UnitedHealthcare Community Plan, this is called a Prior Authorization

You may also find provider information such as:

- Name, address and phone numbers
- Professional qualifications
- Board certification status

Augmentative and Alternative Communication (AAC)

An AAC system provides a member with a different or added ways to tell their wants, needs and thoughts. People of all ages can use AAC if they have trouble with speech or language skills. Augmentative means to add to someone's speech. Alternative means to be used instead of speech. The AAC system should be used by the member in all settings (home, school, community).

How to start the AAC process?

1. A Member receives from their doctor a signed script/referral for an AAC evaluation by a Speech Language Pathologist (SLP). This script/referral is good for 12 months.
2. Members may call UHCCP's Member Services by dialing the number on their UHCCP ID card, call their assigned UHCCP LTC Case Manager to assist in finding an in-network UHCCP licensed and registered AAC therapy provider.

Members may also find a list of AAC Provider Therapy agencies located on UHCCP's member website, **https://www.uhccommunityplan.com/az** — Arizona Health Plans | UnitedHealthcare Community Plan: Medicare & Medicaid Health Plans (**uhccommunityplan.com**). Choose the appropriate plan:

– Long Term Care

Under section, **"Find providers and coverage for this plan"** click on **"Provider Lookup."** Under **Provider Directories**, click on the **"Augmentative and Alternative Communication Service Providers"** hyperlink to view the list of providers. UHCCP staff will assist in seeing the availability of providers and will help in scheduling an appointment.

3. Once the member chooses an SLP, the member calls the SLP to schedule an AAC evaluation. The Member may call Member Services should they run into any barriers with scheduling.
4. The evaluation requires a Prior-Authorization (PA). The SLP will send to UHCCP the member's ISP (if applicable), IEP, therapy progress notes, signed script/referral from the doctor, and other documentation to support the need for an evaluation.
5. A specialty appointment is to be scheduled within 45 days of when the member calls and asks for the evaluation.
6. Once UHCCP receives the PA, a decision must be made within 14 days.
7. If the evaluation is approved, the SLP will call the member to schedule the appointment.
8. If the evaluation is not approved, members will get a Notice of Adverse Benefit Determination (NOA) letter in the mail that explains the reasons for the decision and will include member's appeal rights.

How will member receive the device?

1. The AAC device will be mailed directly to the member's home or therapy office. This is dependent on the member's choice and is included in the order to the AAC DME Vendor.
2. Once the member receives the AAC device, the member should call the AAC Agency to schedule training for the AAC device. The member's assigned UHCCP LTC Case Manager can assist in scheduling the appointment.
3. If the device is shipped to the AAC Agency, the agency will contact the family to schedule the training. If help is needed, the member's assigned UHCCP LTC Case Manager can assist in scheduling the appointment. For help in scheduling appointments, call the number on the back of your ID card.
4. AHCCCS policy requires the first training to be completed no later than 90 days from when the AAC device was approved by the health plan.

UnitedHealthcare Community Plan does not restrict access to services based upon moral or religious principles. This includes counseling or referral services. If a provider refuses to provide services they find objectionable because of moral or religious grounds, we will assist you to get access to another provider who is willing to provide these services. For help, contact Member Services.

American Indian members are able to receive health care services from any Indian Health Service provider or tribally owned and/or operated facility at any time. Indian Health Service Provider may refer the member to a UnitedHealthcare Community Plan provider.

Accessing services

Case Managers work with you to see which health services you need. These are services to help care for you and keep you safe in places such as your home. The cost must usually be no more than the cost for living in a nursing home.

We want to make sure you are living in the best place for your situation. Case Management makes a plan with you to meet your personal care and medical needs during the assessment process. Person-Centered Service Planning is for Case Managers, members and their family, friends, Health Care Decision Makers and caregivers to work together to create and implement a service plan **driven by you and address what is important to and for the member**. This process:

- Builds on member's strengths, life preferences, and support need
- Includes opportunities for meaningful activities such as social connections, employment, community activities and volunteering
- Promotes independence and community inclusion

Social isolation

Social Isolation or loneliness is associated with an increased occurrence or risk factor that could lead to heart disease or depression. Social connections play a key role in maintaining mental and overall physical health. Optum Community Centers offers a great way for people over 55 to stay connected, informed and fit. These are free and available for caregivers too. There are virtual opportunities to stay active as well:
https://www.youtube.com/playlist?list=PLsqiKKQGf-B91F0_ERCPKeijAV7og_fq7

Televeda connects communities together through virtual socialization opportunities with active adults wanting to keep up with their physical health, learning and socialization. Join classes on yoga, writing, technology and more activities are geared for adults and/or caregivers 65+older.
https://www.youtube.com/watch?v=C6irtLpagho

Caregiver supports

A caregiver can be a family member, friend, or professional. People become caregivers often without even knowing that they would be in that role. Most of the time people do not choose to be a caregiver they just happen to fall into that role by an unforeseen situation. The challenges of care giving can lead to stress which potentially can lead to caregiver burnout. Caregiver burnout is a state of physical, emotional, and mental exhaustion. Recognizing the symptoms of burnout such as fatigue, anxiety, depression and getting help could prevent an unhealthy situation from occurring.

United Healthcare Community Plan has supportive services available that can offer coaching and promote wellness activities for the informal caregiver. Contact your Case Manager for more information.

If you have questions, contact your Case Manager. They will visit you to help with your health care needs. They can help you:

- Pick a doctor (PCP)
- Get care with your doctor
- Manage medical services
- Solve problems with your care through goal setting
- Find ways to live at home
- Explain service and placement options
- Help with locating community resources through Member Empowerment (me*) Housing, Education and Employment or Volunteer Program
- Obtain Behavioral Health Services

Visit our website or contact Member Services to obtain a copy of the UnitedHealthcare Community Plan Provider Directory at no cost to you. Our directory contains information about how our providers can meet your cultural, language, or accessibility needs.

You may also find provider information such as:

- Name, address and phone numbers
- Professional qualifications
- Medical school attended (by phone only)
- Residency completion (by phone only)
- Board certification status
- Languages spoken
- Age group served
- Hospital affiliations
- If accepting new patients
- Wheelchair accessibility

Choosing a Primary Care Provider (PCP)

As a member of UnitedHealthcare Community Plan, you must choose a PCP. You will need to pick a PCP who is registered with AHCCCS and contracted with UnitedHealthcare Community Plan. Your Case Manager will provide a list of our providers. Picking a PCP is important. If you are in a nursing home, your PCP will visit you there.

If your current PCP is a UnitedHealthcare Community Plan PCP, you do not need to pick a new PCP. If your current PCP does NOT work with UnitedHealthcare Community Plan, your Case Manager will help you pick a new PCP. Refer to the list of UnitedHealthcare Community Plan PCPs. If you do not pick a PCP, one will be assigned to you. We will then inform you of your PCP's name, address and phone number. You may continue to see your PCP if have primary insurance and/or Medicare.

For Maternity and Family planning, you may choose a Maternity Care Provider, primary care physician or primary care practitioner such as a nurse practitioner, physician's assistant, or midwife. These maternity and family planning providers will ensure you get pre- and postpartum services. The OB ensures you get pre- and postpartum services. These are services before and after your pregnancy.

How do I change my PCP?

You can change your PCP

Usually it is better to stay with the same PCP. Your PCP knows you and has your records and knows what medications you take. Your PCP is the best person to make sure you get good care. There may be a time you want to change PCPs. If so, call or write your Case Manager. They will send you a list of UnitedHealthcare Community Plan providers to pick from. Or you can go to **https://www.uhccommunityplan.com/az/medicaid/long-term-care.html**. Once you have chosen your new PCP, let your Case Manager know right away. Your PCP change will happen on the first day of the month after we get your written request.

Some reasons you may change your PCP:

- You have moved and need a PCP closer to your home
- You are not happy with your PCP

Some reasons you may not change your PCP:

- You asked for a PCP who is not with AHCCCS
- You asked for a PCP who is not taking new patients

Your PCP may ask you to change to another PCP if:

- You and your PCP do not get along
- You do not follow your PCP's advice
- You are late or do not show up for appointments

If you lose and regain AHCCCS eligibility within 90 days, you will be re-enrolled with the same PCP, if they are still in the plan.

How do I make appointments?

Your PCP and Case Manager will work with you to get the care you need. PCPs are required to provide coverage 24 hours a day, 7 days a week. If you need an immediate or urgent appointment and your PCP is not able to give you one, they may refer you to an urgent care or emergency room. You may call UnitedHealthcare Community Plan at **1-800-293-3740**, TTY **711** for help. Try to set up PCP visits as far ahead as possible. Your PCP sees many patients every day.

If you need help making an appointment, call your Case Manager. If you are in a nursing or assisted living facility, ask the staff to help you; if they cannot, call your Case Manager.

PCP appointments

Urgent care:	Appointments are to be scheduled as soon as the member's health condition require, but no later than 2 business days of request.
Routine care:	Within 21 calendar days of the request.

Canceling or changing appointments

Call at least 24 hours in advance of your appointment or as soon as possible to cancel or change appointments (PCP and Specialist). If you miss more than one visit without calling, your doctor may not see you again.

Well visits

Well visits (well exams) are covered for members. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling, and medically necessary immunizations. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visits for members under 21 years of age are considered the same as a well visit.

How can I be involved in my health care?

Be involved in your care by seeing your PCP often. You will take part in choices about your care. Your PCP will provide or arrange the covered services you need. Make sure you talk to your PCP about any health problems you have. That way, your PCP gets to know you and your medical history. Be sure and tell your PCP about any behavioral health issues as well. Your PCP may be able to treat behavioral health conditions or you may get behavioral health services without a referral. Always follow your PCP's instructions and get approval before you get any medical services. We will send you newsletters with helpful information about health care. We will also tell you about new things going on with your plan.

In addition, we may send you surveys about your health and UnitedHealthcare Community Plan. Completing these surveys is another way to take part in your health care.

Take advantage of these materials

We want you to feel in control of your health and your health care. We have many brochures that can be of help to you. They include:

- **Preventive care** — Preventive Services Reminder, Immunizations, Glaucoma Screenings, Glucose or Blood Sugar Screenings, and Mammography
- **Chronic conditions** — Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Heart Failure, Coronary Artery Disease, Taking Charge of Blood Pressure, Spinal Stenosis, Dementia, Depression, Dysrhythmia, Peripheral Vascular Disease, Deep Vein Thrombosis and Pulmonary Embolisms, Neuropathic Foot Care
- **Ways to keep your living area safe**
- **You Can Quit Smoking** brochure
- **Flu and Pneumonia Vaccination Information** — Signs and Symptoms of the Flu, Caring for the Flu, Flu Guide — Q & A, **No More Excuses** brochure

To get brochures, contact your Case Manager or call Member Services at 1-800-293-3740, TTY **711**. You also can review your Plan of Care at **myuhc.com/CommunityPlan**.

What types of care are available for children?

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and behavioral health conditions for AHCCCS members under the age of 21.

The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources.

EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age.

Amount, duration and scope:

The Medicaid Act defines EPSDT services to include screening services, vision services, replacement and repair of eyeglasses, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

This means that EPSDT covered services include services that correct or ameliorate physical and behavioral health conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “medical assistance” as defined in the Medicaid Act. Services covered under EPSDT include all categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and X-ray services, physician services, naturopathic services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical equipment, medical appliances and medical supplies, orthotics, prosthetic devices, eyeglasses, transportation, family planning services and supplies, women’s preventive care services, and maternity services when applicable. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services. However, EPSDT services do not include services that are experimental, solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

Healthy weight – Tips to help children maintain a healthy weight

Childhood obesity is a complex disease with many contributing factors, including genetics, eating patterns, physical activity levels, and sleep routines. Conditions where we live, learn, work, and play can make healthy eating and getting enough physical activity difficult if these conditions do not support health.

During well-child visits, your child's doctor checks Body Mass Index (BMI) to see if your child has a healthy weight for their age, sex, and height. If you are concerned about your child's weight, talk to your child's doctor about their BMI. For more information about Tips to Help Children Maintain a Healthy Weight go to **www.cdc.gov/healthyweight/children**.

Lead exposure – Prevent childhood lead exposure

Lead is a metal found naturally in the environment and has been used in many products, including paint and gasoline. People can become exposed to lead by swallowing or breathing in lead dust which causes lead poisoning. When lead gets into the body, it can be harmful and cause irreversible effects. Young children are at greater risk for lead poisoning. A blood test is the best way to determine if a child has been exposed to lead. Be sure to talk to your child's doctor about the risks of lead poisoning during your child's next well-child visit.

Testing the blood for lead is required for all children at 12 months and 24 months of age. Your child may be at risk for having lead poisoning if your child lives in a high-risk ZIP code. To learn if your ZIP code is high risk, visit **https://www.azdhs.gov/gis/childhood-lead**.

Women's Preventive Care Services

Well-woman preventative care visits are covered for members on an annual basis. The well woman preventive care visit includes the following services:

- A physical exam (Well Exam) that assesses overall health
- Clinical breast exam
- Pelvic exam (as necessary, according to current recommendations and best standards of practice)
- Review and administration of immunizations, screenings, and testing as appropriate for age and risk factors
  - Human Papillomavirus (HPV) vaccines are covered as recommended by the Centers for Disease (CDC) **https://www.cdc.gov/hpv/parents/vaccine-for-hpv.html**

- Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks and addresses at a minimum the following:
  - Proper nutrition
  - Physical activity
  - Elevated BMI indicative of obesity
  - Tobacco/substance use, abuse, and/or dependency
  - Depression screening
  - Interpersonal and domestic violence screening, that includes counseling about current or past violence and abuse and addresses current or future health concerns about safety
  - Sexually transmitted infections
  - Human Immunodeficiency Virus (HIV)
  - Family Planning Services and Supplies
- Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
  - Reproductive history and sexual practices,
  - Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake,
  - Physical activity or exercise,
  - Oral health care,
  - Chronic disease management,
  - Emotional wellness,
  - Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and
  - Recommended breaks between pregnancies.
- Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified

Pregnancy/maternity services

UnitedHealthcare Community Plan knows that healthy moms have healthy babies. That is why we take special care of all our moms-to-be. UnitedHealthcare Community Plan has a program called Healthy First Steps for UnitedHealthcare Community Plan members. Healthy First Steps provides information, education and support to help reduce problems while you are pregnant. Health First Steps engages and rewards members for keeping prenatal and postpartum care appointments through the infant's first 15 months of life. If you think you may be pregnant or as soon as you know you are pregnant, call Healthy First Steps at 1-800-599-5985. or visit our website at **UHCHealthyFirstSteps.com**.

Female members, or members assigned female at birth, have direct access to preventive and well care services from a PCP, OB/GYN or other maternity care provider within the Contractor's network without a referral from a primary care provider. Preventive services such as cervical cancer screening or referral for a mammogram are covered.

Noninvasive pregnancy testing for high risk pregnancies are covered.

As a member, UnitedHealthcare Community Plan will help you:

- Choose a Maternity Care Provider, licensed physician, nurse practitioner, physician assistant, Certified Nurse Midwife (CNM), or Licensed Midwife (LM) for pregnancy care
- Get information about Healthy First Steps — a maternity program for you and your baby where you can earn rewards for completing prenatal and postpartum care appointments. You can call Healthy First Steps at 1-800-599-5985 or enroll online at **http://www.uhchealthyfirststeps.com**.
- Access the Maternal Child Health Home Visiting Programs for pregnant women and families with children birth to age 3. There is no cost and a trained home visitor comes to the home to help families with education on topics such as: parenting, breastfeeding, employment and child care solutions, child abuse/child neglect prevention, child development, and school readiness.
- Schedule appointments and exams as well as help with scheduling medically necessary transportation
- Choose a pediatrician (child's doctor) or a family medicine doctor for your new baby
- Choose a PCP for you after the birth or return to the PCP you had before your pregnancy. Call Member Services after your delivery.
- Get information on community programs such as WIC (Women, Infants, and Children). You can call WIC at 1-800-252-5942.
- Get information on community programs such as Children's Information Center for car seats, child care, breastfeeding, and other resources. You can call the Office for Children with Special Health Care Needs at **1-800-232-1676** or send an email to **OCSHCN@azdhs.gov**.

- Get answers to your breastfeeding questions 24 hours a day by calling the Arizona Department of Health Services' **24-Hour Breastfeeding Hotline** at **1-800-833-4642** or by visiting **www.gobreastmilk.org**
- **National Maternal Mental Health Hotline | MCHB** (**hrsa.gov**)
  24/7,no cost, Confidential Hotline for Pregnant and New Moms in English and Spanish
  Call or text 1-833-943-5746 (1-833-9-HELP4MOMS). TTY users can use a preferred relay service or dial 711 and then 1-833-943-5746.

Your doctor will give you:

- Care before and after your baby is born (no copayments)
- Information about having a healthy pregnancy, such as good nutrition, quitting smoking, and exercise
- Information about childbirth options and childbirth classes
- Help with family planning choices and services after your baby's birth (including but not limited to birth control pills, condoms, and sterilizations)

Prenatal care appointment time frames

- First Trimester — Within 14 calendar days of request for appointment
- Second Trimester — Within 7 calendar days of request for appointment
- Third Trimester — Within 3 business days of request for appointment
- High-Risk Pregnancy — Appointments are to be scheduled as soon as the member's health condition requires, but no later than 3 business days of identification of high risk by UnitedHealthcare Community Plan or a maternity care provider, or immediately if an emergency exists

Your appointments are very important to your health and the health of your baby. You should see your doctor during pregnancy even if you feel good. If you need to change your appointment, contact your doctor before your appointment. See your doctor after your baby's birth (postpartum care). Call your doctor for the timing of this appointment. If you had a cesarean section, your doctor may want to see you sooner.

At your postpartum checkup, your doctor will:

- Check to make sure you are healing well
- Screen you for postpartum depression
- Do a pelvic exam to make sure reproductive organs are back to pre-pregnancy condition
- Answer questions about breastfeeding and examine your breasts
- Address questions about having sex again and birth control options

Any member can have a Human Immunodeficiency Virus (HIV) test at anytime. If you are pregnant and have HIV, the virus can be passed to your fetus. The good news is that treatment during pregnancy and treating the baby after birth can greatly reduce the chance of this happening. Treatment during pregnancy can also help you stay healthy. If your test is positive, you can get specialty treatment and medical counseling. Talk to your PCP, Maternity Care Provider, or contact your local department of public health for testing. HIV/STI testing are also available at the Arizona Family Partnership **602-258-5777** or **1-888-272-5652** or visit the website at **www.arizonafamilyhealth.org**. Planned Parenthood also offers testing and services. Call **1-800-230-7526**.

Knowing all your options for birth control can help you choose the right method for you. Long-acting Reversible Contraceptive (LARC) options are a good choice for many women (including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), and there is no copay, charge or cost. These include:

- Intrauterine device (IUD) — A small, T-shaped plastic and or copper device that your doctor places in your uterus, or
- Birth control implant — A small rod the size of a matchstick that your doctor places under the skin on your arm.

If you are pregnant and you have been seeing a doctor that is not in our network, you may be able to change plans. This is because you may have a medical continuity of care issue during your pregnancy. Please see "Changing Plans" earlier in this handbook.

If you find out you are no longer pregnant, call your Case Manager or Member Services. They will help you arrange any health care services or changes you may need.

If you have questions or need help getting Behavioral Health Services, please call your Case Manager the number on your ID card. Please see page 11 of this handbook for Behavioral Health crisis information and pages 63–74 for additional information about Behavioral Health Services.

If experiencing a behavioral health crisis call:

Statewide Crisis Hotline	**1-844-534-HOPE (4673)** or **988**
You may also text	**4HOPE (44673)**

Crisis hotlines by county:

Gila, Maricopa Counties	**1-800-631-1314**
Apache, Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties	**1-866-495-6735**
Coconino, Mohave, Navajo and Yavapai Counties	**1-877-756-4090**
Gila River and Ak-Chin Indian Communities	**1-800-259-3449**
Salt River Pima Maricopa Indian Community	**1-855-331-6432**
Tohono O'Odham Nation Community	**1-844-423-8759**

Family planning services and supplies

Family planning services and supplies help you protect yourself from having an unwanted pregnancy and/or contracting a sexually transmitted disease. Both men and women regardless of gender, who voluntarily chose to delay or prevent pregnancy, are eligible to receive family planning services and supplies. When requirements are met, sterilization services are covered regardless of member's gender.

For family planning services and supplies, you may choose a maternity care or family planning provider such as a physician, nurse practitioner, physician's assistant, nurse midwife, or midwife, without a referral, and regardless of whether or not the family planning service providers are network providers. Family planning services are also available from any Planned Parenthood (1-800-230-7526) office statewide. Family planning services and supplies do not require a referral, or prior authorization may be supplied by non-contracted AHCCCS registered providers, and are offered at no copayment and no cost to you. Medically necessary transportation services are available.

Knowing all your options for birth control can help you choose the right method for you. Long-acting Reversible Contraceptive (LARC) options are a good choice for many women (including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), and there is no copay, charge or cost. These include:

- Intrauterine device (IUD) — A small, T-shaped plastic and or copper device that your doctor places in your uterus, or
- Birth control implant — A small rod the size of a matchstick that your doctor places under the skin on your arm.

Benefits of Long-Acting birth control options include:

- They are 99 percent effective
- They work better than the pill and barrier methods
- They last three to ten years, depending on which type you choose
- They are convenient. There are no prescriptions to refill or pills to remember to take.
- They are reversible. When you want to get pregnant you can have them removed.

In addition to the IUD and birth control implant, covered family planning services and supplies also include, but are not limited to, the following:

- Birth control pills: Pill taken every day
- Condom (rubber)
- Depo Provera: Shot given every 3 months for women

- Diaphragm: Vaginal removable barrier worn by women
- Emergency contraceptive pill (ECP): Pill taken after unplanned sex to prevent pregnancy
- Family planning counseling services
- Family planning lab services
- Natural family planning
- Pregnancy screening
- Radiological procedures, including ultrasound studies related to family planning
- Screening, testing, and treatment for Sexually Transmitted Infections (STIs)
- Spermicidal jelly, cream, foam, or suppositories
- Treatment of complications resulting from contraceptive use, including emergency treatment
- Tubal ligation: Surgical procedure for women 21 and older
- Vasectomy: Surgical procedure for men 21 and older

The following are not covered for the purpose of family planning services:

- Infertility services including diagnostic testing, treatment services or reversal of surgical infertility
- Pregnancy termination counseling
- Pregnancy terminations (see section below for situations when medically necessary pregnancy terminations are covered)
- Hysterectomy

Regardless of gender, if you lose eligibility for AHCCCS services, UnitedHealthcare Community Plan can help you find low-cost or no-cost family planning services, call your Case Manager or call the Arizona Department of Health Services Hotline at 1-800-833-4642. Planned Parenthood provides low-cost family planning services. You can call 1-800-230-7526 for the office closest to you. Arizona Family Health Partnership can also help you find low- or no-cost family planning services. Contact Arizona Family Health Partnership at 602-258-5777 or 1-888-272-5652 if you live outside of the Phoenix area.

If you need treatment for a sexually transmitted infection (STI), contact your doctor, an STI Specialist, or the Arizona Department of Health Services at 602-542-1025. Services provided by the Arizona Department of Health Services are also available to you if you lose AHCCCS coverage. We can also help you find low-cost or no-cost primary care services if you lose eligibility. If you need help finding these services, call Member Services.

Medically necessary pregnancy terminations

Pregnancy terminations are an AHCCCS covered service only in special situations. AHCCCS covers pregnancy termination if one of the following criteria is present:

1. The pregnant woman suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
2. The pregnancy is a result of incest.
3. The pregnancy is a result of rape.
4. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or Behavioral Health problem for the pregnant woman by:
   - Creating a serious physical or Behavioral Health problem for the pregnant woman,
   - Seriously impairing a bodily function of the pregnant woman,
   - Causing dysfunction of a bodily organ or part of the pregnant woman,
   - Exacerbating a health problem of the pregnant woman, or
   - Preventing the pregnant woman from obtaining treatment for a health problem.

Dental care

We feel that dental care is just as important as other care you receive. That's why we assign all of our members to a dental home. This is like your Primary Care Physician, but for dental care.

Routine dental services are covered for members under the age of 21. Some of these services include:

- Dental exams, two per year
- Application of topical fluoride
- Fillings for cavities
- Dental sealants
- Dental cleanings
- Emergency dental services
- X-rays to screen for dental problems

Members 21 years of age and older have a $1000 benefit for routine dental services, including dentures, and a $1000 benefit for emergency dental services for each 12 month period beginning October 1st through September 30th.

The dental limit for American Indian and Alaskan Native members when receiving dental services at an IHS/638 Facility has been removed. Services performed outside of the IHS/638 tribal facilities remain limited to the $1,000 emergency dental benefit for members 21 years of age and over, and the additional $1,000 for dental services for Long Term Care members.

You would see your dental home for your dental care. We send you the name and address of the dentist you are assigned to in the mail. If you want to change your dental home, call **1-800-293-3740**, TTY **711**. Please call your dentist to schedule an appointment. Members can receive preventive visits two times per year (every six months).

Dental providers can be found on the **myuhc.com/CommunityPlan** or **https://www.uhccommunityplan.com/az/medicaid/long-term-care.html** website. Or you can call your Case Manager for help finding a provider and making dental appointments.

Cancelling or changing your dental appointment

If you need to cancel or change your dental appointment, please call your dental provider at least 24 hours in advance of the appointment. Reschedule your appointment for another time.

Dental provider appointments:

For urgent dental appointments members will be seen as soon as the member's health condition requires, but no later than 3 business days of request. Routine appointments are within 45 calendar days of request. For urgent dental specialty provider appointments, member's will be seen as soon as the member's health condition requires, but no later than 2 business days from the request. Routine specialty appointments are within 45 calendar days of request. To find a dentist or dental specialist visit **UHCCommunityPlan.com** or call Member Services at **1-800-293-3740**.

Getting your prescriptions (medications)

Getting prescription medications is an important part of your health care. If your AHCCCS registered doctor prescribes a medicine that's listed on your plan's preferred drug list (PDL), it's covered, less any possible copay (this list is also known as a formulary.) If your medication is not listed on the PDL, your care provider may request an alternative medication for you that is listed on the PDL. UnitedHealthcare Community Plan covers medicines on this list and may pay for other medicines with prior approval. See below for information on prior approval. You can get your prescriptions filled at any pharmacy in our network. Many are available 24 hours a day, 7 days a week. For a list of pharmacies or to look up medications on the Preferred Drug List, use your provider directory or go to **myuhc.com/CommunityPlan**.

If you have a problem getting your prescription during normal business hours, call Member Services. If you have a problem getting your prescriptions after normal business hours, on weekends, or holidays, have your pharmacist call the pharmacy help desk. This number is on the back of your ID card.

Medicaid does not cover medications eligible for coverage under Medicare Part D or Medicare copayments, coinsurance, or deductibles for Medicare Part D medications. Unless, you are only enrolled in Medicare Part A and have credible prescription drug coverage.

Prior approval

Prior approval (authorization) of prescription medications

If your prescription medication is not listed on the PDL, or is listed but requires prior approval, your care provider can request prior approval for you, so you can still get that medication. We will approve or deny the request within 24 hours. If a request is approved, you and your primary care provider (PCP) will be informed of the decision in writing including the medication approval length of time. If a request is denied, you and your PCP will be informed of the decision in writing. The written decision notice will tell you how and when to appeal this decision and how to file a complaint or grievance with UnitedHealthcare Community Plan.

90 day supply benefit

Members can fill a 90 day supply of select maintenance medication at the retail pharmacy. Maintenance medications are typically those medications you take on a regular basis for a chronic or long term condition.

With a 90 day supply, you won't need to get a refill every month. To find out more details, talk to your doctor or pharmacist. For a complete list of medications included in this benefit call Member Services.

You have the ability to get maintenance medications by mail order. If you qualify, you can get a 90-day supply of your maintenance medications by mail and you won't need to get a refill every month. Call Member Services for more information and to request a Mail Order Enrollment form.

Prescription drug monitoring

UnitedHealthcare Community Plan ensures the member receives the appropriate medication, dosage, quantity and frequency by monitoring prescription patterns by members, providers and pharmacies. The review requirements are to determine the misuse of drugs or over-utilization of drugs.

There may be situations where the plan feels it's necessary to limit a member to a single pharmacy or prescribing physician due to inappropriate prescription use. This is called an exclusive pharmacy. You will be provided with a written letter explaining the reasons for this limitation before it happens. This letter will also include your right to appeal. The situations that can result in limiting a member to a single pharmacy or prescribing physician are listed below:

Over-utilization	Member utilized the following in a 3 month time period: • 4 or more prescribers; and • 4 or more abuse potential drugs (e.g. opioids, muscle relaxers, tranquilizers); and • 4 or more pharmacies. **Or** Member has received 12 or more prescriptions of the medications of concern (drugs with abuse potential) in the past three months.
Fraud	Member has presented a forged or altered prescription to the pharmacy.

How to safely throw out unused prescription medications

Keeping old medications around your home can be unsafe as they can be taken accidentally or misused. That's why you should get rid of unused or expired medicine as soon as possible.

1. **Ask your local pharmacy**

   Contact your local pharmacy to see if they have a medication take-back program. You may be able to drop them off in person or send them in a special package provided by the pharmacy.

2. **Use a community drug take-back program**

   If you have unused controlled substances, such as opioid, a community take-back site is the preferred way to dispose of them. Some sites will also accept them by mail in special packaging.

3. **If a drug take-back or collection program is not available, you can throw away your medicines at home by following these steps:**
   - Mix the unused supply with an unappealing substance such as dirt, coffee grounds or kitty litter
   - Put the mixture into a disposable container with a lid, such as an empty margarine tub, or into a seal-able bag, then place the sealed container in your trash
   - Make sure to hide or remove any personal information, including prescription number, on the empty drug containers by covering it with black permanent marker or duct tape, or by scratching it off to protect your privacy
   - Place the containers in the trash
   - Only flush approved unused or expired medications down the toilet if indicated on the label, patient information or when no other disposal options are available
4. **Find additional information and resources on safe drug disposal from these government websites:**

   The U.S. Drug Enforcement Administration (DEA)
   www.DEATakeBack.com or

   The U.S. Department of Health and Human Services
   www.hhs.gov/opioids/prevention/safely-dispose-drugs/index.html

Behavioral Health Services

If you need Behavioral Health Services, contact your Case Manager. Behavioral Health Services are available to treat both mental health and substance use disorders. Your Case Manager can help pick a provider. You can also self-refer by calling a provider from the provider directory. Your Case Manager will give you a directory or you can go online at **https://www.uhccommunityplan.com/az/medicaid/long-term-care.html**.

You have the right to accept or refuse Behavioral Health Services offered to you. If you want to get the Behavioral Health Services offered, you or your legal guardian must sign a "Consent to Treatment" form. This form gives you or your legal guardian's permission for you to get Behavioral Health Services. When you sign a "Consent to Treatment" form, you're also giving AHCCCS permission to access your records.

To give you certain services, your provider needs to get your permission. Your provider may ask you to sign a form or to give verbal permission to get a specific service. Your provider will give you information about the service so you can decide if you want that service or not.

This is called informed consent. Informed consent means advising a patient of a proposed treatment, surgical procedure, psychotropic drug or diagnostic procedure; alternatives to the treatment surgical procedure, psychotropic drug or diagnostic procedure; associated risks and possible complications; and getting documented authorization, or approval for the proposed treatment, surgical procedure, psychotropic drug or diagnostic procedure from the patient or the patient's family, health care decision maker or designated representative.

Members are assessed for their health care needs and social determinants of health by their PCP, Behavioral Health provider, or their Case Manager. A member's assessment may indicate a housing need. Supported housing services are designed to assist individuals or families to obtain and maintain housing in various settings depending on member need, with emphasis on independent community settings including the person's own home or apartments and homes owned or leased by a subcontracted provider.

Your Case Manager can help you understand your Behavioral Health benefit. Covered Behavioral Health Services include, but may not be limited to, the following:

- Behavioral Health medicines, monitoring, and adjustment
- Behavioral Health therapeutic home care services
- Behavior management (personal care, family support/home care training, peer support)
- Doctor services

- Emergency and non-emergency transportation
- Emergency Behavioral Health care
- Individual, group and family therapy and counseling
- Inpatient hospital services, detoxification, and Behavioral Health residential services
- Inpatient psychiatric facility services
- Laboratory and radiology services
- Partial care (supervised day program, therapeutic day program, specialized outpatient substance use program and medical day program)
- Psychosocial rehabilitation (living skills training; health promotion; supported employment services)
- Rehabilitation services
- Respite care — with limits
- Screening, evaluation, and diagnosis
- Substance use (drug, opioid, and alcohol) counseling, medication assisted treatment
- Support services
- Treatment planning

You may self-refer to a Behavioral Health provider, or be referred by providers, schools, State agencies, or other parties. You may see a Behavioral Health counselor, addiction specialist, psychologist, or psychiatrist without a referral from your PCP. To access Behavioral Health Services call your Case Manager, the Behavioral Health number on your ID card, use your provider directory or visit our website at **https://www.uhccommunityplan.com/az/medicaid/ long-term-care.html**.

What if I am experiencing a Behavioral Health crisis?

If you are experiencing a Behavioral Health crisis it is important for you to get help right away. Please call the new single statewide crisis line 1-844-534-HOPE (4673) or **988**. You may also text 4HOPE (44673) or the crisis number of your area located on page 12 of this handbook.

All members are covered for Behavioral Health Services in a crisis or emergency situation.

Behavioral Health appointments are to be scheduled as soon as the member's health condition requires but no later than the following:

Urgent Behavioral Health appointments — Are within 24 hours from the identification of need.

Routine care appointments — The initial assessment to be completed within 7 calendar days of referral or request. The first Behavioral Health service following the initial assessment is as soon as the member's health condition requires but for members age 18 or older, no later than 23 calendar days after the initial assessment and for members under the age of 18 years old, no later than 21 days after the initial assessment. All other Behavioral Health Services to be completed as soon as the member's health condition requires, no later than 45 calendar days.

Behavioral Health appointments for members in legal custody of the Arizona Department of Child and Safety (DCS) and adopted children are to be scheduled:

Rapid response — When a child enters out-of-home placement within the timeframe indicated by the behavioral health condition, but no later than 72 hours after notification by DCS that a child has been or will be removed from their home.

Initial assessment — Within seven calendar days after referral or request for behavioral health services.

- Initial appointment — Within timeframes indicated by clinical need, but no later than 21 calendar days after the initial assessment, and
- Subsequent Behavioral Health services — Within the timeframes according to the needs of the person, but no longer than 21 calendar days from the identification of need.

If you feel you may harm yourself or others, call 911 for emergency help. If you are experiencing a mental health crisis, call 988.

For referrals for Behavioral Health medications

For Behavioral Health the need will be immediately assessed. An appointment will be scheduled no later than 30 calendar days from the identification of need. If you are running out of medication or if you have a decline in your Behavioral Health condition prior to starting medication you can be seen sooner.

For psychotropic medications the need will be immediately assessed to ensure the member does not run out of the needed medication or does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

Substance Use Disorder Helpline: 855-780-5955

The Substance Use Disorder Helpline is a free, anonymous resource available 24 hours a day, 7 days a week for all UnitedHealthcare Community Plan members who are seeking help for themselves or a loved one who need help with Substance Use Disorder, Alcohol Use Disorder, or Opiate Use Disorder.

The Substance Use Disorder Helpline is available **24 hours a day, 7 days a week** and offers direct access to a licensed Behavioral Health Clinician/Specialized Substance Use Recovery Advocate (SURA) who can provide assistance and provider referrals. Substance use disorders occur when the recurrent use of alcohol, tobacco, or drugs (including opioids, marijuana, stimulants, and hallucinogens) causes significant impairment — such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Some examples of when to call the Substance Use Disorder Helpline:

- You may be using substances inappropriately and are at risk of abuse or addiction
- You are looking for help, but are too embarrassed to ask for it
- You have concerns about your substance use, or the substance use of a friend or loved one
- You have questions about the treatment of addiction, and what your insurance plan will cover
- You are seeking providers who specialize in the treatment of substance use disorders

Substance Use Disorder is a disease

Those suffering from any form of Substance Use Disorder need emotional support, empathy, and evidence-based treatment in order to recover — just like any other serious illness.

Members who have a Serious Mental Illness (SMI) or a Severe Emotional Disturbance

A Serious Mental Illness (SMI) is a chronic and long term mental health condition which impacts a person's ability to perform day-to-day activities or interactions. SMI qualifying diagnoses include: Psychotic Disorders, Bipolar Disorders, Obsessive-Compulsive Disorder, Depressive Disorder, Other Mood Disorders, Anxiety Disorders, Post Traumatic Stress Disorder, Dissociative Disorder and Personality Disorders.

If you think you have a SMI but have not been determined as such, a SMI eligibility evaluation can be obtained at any qualifying AHCCCS Behavioral Health intake provider. Please call Member Services at **1-800-293-3740**, TTY **711** for more information on how to be connected with a qualified AHCCCS Behavioral Health provider or talk with your Case Manager. A member must be 17 and a half years of age or older to be assessed for SMI eligibility. A member or the member's guardian must provide consent to be assessed. In order to be eligible for SMI services, the member must have a qualifying diagnosis and functional impairment as a result of the qualifying diagnosis.

Members requesting an SMI determination must be assessed by a qualified provider within 7 days of their request. An SMI determination will be issued by the determining entity Solari Crisis & Human Services within 3 business days of the assessment. Solari Crisis & Human Services is the designated entity responsible for managing all SMI eligibility determination appeals. All other Behavioral Health related appeals are processed by UnitedHealthcare Community Plan. Solari Crisis & Human Services will provide written notice of their decision with appeal instructions if the member disagrees with their decision. For more information about Solari Crisis & Human Services timelines visit: **https://crisis.solari-inc.org** or you can call Solari Crisis & Human Services at 1-855-832-2866.

Members who are already determined to be SMI may be eligible to receive:

- Special Assistance
  - Special Assistance is support provided to an individual who is unable due to a specific condition to communicate his/her preferences and/or to participate effectively in the development of his/her service plan, discharge plan, the appeal process and/or grievance/investigation process
  - If you need Special Assistance please speak with your Behavioral Health provider, Case Manager, or contact AHCCCS Office of Human Rights at 1-800-421-2124

Members who are determined to have a Serious Mental Illness and who are enrolled in one plan for both physical health and behavioral health services may request a different plan for their physical health services. This is called an opt-out request. An opt-out will only be approved for the member under one of the following conditions:

1. The network does not allow choice from at least two PCPs, or it does not have a needed specialty provider,
2. The current treating physician says there is a need to continue a course of treatment.
3. There is evidence of harm or unfair treatment.

If you would like to ask for an opt-out, contact Member Services at **1-800-293-3740**, TTY **711**.

Severe Emotional Disturbance (SED)

Severe Emotional Disturbance (SED) is a designation for individuals from birth until the age of 18 who have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria, which interferes with or limits the child's role or functioning in family, school, or community activities.

Please call Member Services at **1-800-293-3740** for more information on how to be connected with a qualified AHCCCS behavioral health provider.

Sanvello

On-demand help with stress, anxiety and depression

Sanvello is an app that offers clinical solutions to help dial down the symptoms of stress, anxiety and depression — anytime. Connect with powerful tools that are there for you when symptoms come up. Stay engaged for each day for benefits you can feel. Use Sanvello whenever you need to, track your progress and stay until you feel better. You can upgrade to premium at no cost by following these steps:

1. Download the app at **sanvello.com** and open it.
2. Create an account and choose "upgrade through insurance."
3. Search for and select **UnitedHealthcare**, then enter the information available on your UnitedHealthcare medical insurance card.

Download today

More information is available at **sanvello.com**. Email **info@sanvello.com** with any questions.

Court-ordered evaluation and court-ordered treatment

Court-ordered evaluation (COE) and court-ordered treatment (COT) are designed to help people who are unwilling to or incapable/unable of providing consent to receive behavioral health services and who meet legal criteria for the State of Arizona to step in and compel (mandate or order) them to receive treatment.

Court-ordered evaluation (COE)

In Arizona, COE is a process in which two behavioral health medical professionals each complete a detailed analysis of an individual identified as potentially meeting one or more of the four criteria.

The court-ordered evaluation may include firsthand (observed by the professional completing the evaluation) or remote or secondary observations from others (by family, friends, social or community supports, or other treatment providers) that describe, in detail, the individual's: Danger To Self (DTS), Danger To Others (DTO), Persistently or Acutely Disabled (PAD) and/or Gravely Disabled (GD).

If it is determined that the individual meets one of the four criteria for court-ordered treatment, the medical professionals who completed the evaluation will submit their findings to the superior (county) court where the individual resides or where they received the evaluation. A judge will hear the case and determine whether the individual meets the criteria to be ordered into treatment.

Court-ordered treatment (COT)

In Arizona, COT is behavioral or mental health treatment that is ordered by a superior (county) court according to the Arizona Revised Statute Title 36 processes.

An individual can be ordered by the court to undergo mental health treatment if, because of a mental disorder, the individual is determined to be a danger to themselves, a danger to others, is persistently or acutely disabled, or is gravely disabled.

In Arizona, a mental disorder is defined as: a substantial disorder of the person's emotional processes, thought, cognition, or memory. Individuals living with substance abuse disorders, intellectual/developmental disabilities, or disorders that are a result of lifelong and deeply ingrained antisocial behavior patterns are not eligible for COT, unless these behavior patterns are the result of a different mental disorder that meets the legal criteria according to the statute.

If you believe an individual is in immediate need of assistance due to being a danger to them-self or others, call 911, 988, 844-534-4673 (HOPE) or a local crisis hot-line in your county (see page 12 for reference to crisis numbers in handbook).

If you believe the situation is not immediately urgent but you would like to start the process of 'Pre-petition Screening' to see if a person is appropriate for a Court-ordered Evaluation (COE), contact your local/county screening provider or LTC Case Manager who can assist you with the paperwork and start the process of evaluation.

Arizona's vision for the delivery of Behavioral Health Services

All Behavioral Health Services are delivered according to the following system principles. AHCCCS supports a Behavioral Health delivery system that is consistent with AHCCCS values, principles, and goals:

1. Timely access to care,
2. Culturally competent and linguistically appropriate,
3. Promotion of evidence-based practices through innovation,
4. Expectation for continuous quality improvement,
5. Engagement of member and family members at all system levels, and
6. Collaboration with the Greater Community.

The 12 principles for the delivery of services to children

1. **Collaboration with the child and family:**
   a. Respect for and active collaboration with the child and parents is the cornerstone to achieving positive Behavioral Health outcomes, and
   b. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of Behavioral Health Services, and their preferences are taken seriously.
2. **Functional outcomes:**
   a. Behavioral Health Services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
   b. Implementation of the Behavioral Health Services plan stabilizes the child's condition and minimizes safety risks.

3. **Collaboration with others:**
   a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established Behavioral Health Services plan is collaboratively implemented,
   b. Client-centered teams plan and deliver services,
   c. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Division of Child Safety (DCS) and/or Division of Developmental Disabilities (DDD) caseworker, and the child's probation officer, and
   d. The team:
      i. Develops a common assessment of the child's and family's strengths and needs,
      ii. Develops an individualized service plan,
      iii. Monitors implementation of the plan, and
      iv. Makes adjustments in the plan if it is not succeeding.
4. **Accessible services:**
   a. Children have access to a comprehensive array of Behavioral Health Services, sufficient to ensure that they receive the treatment they need,
   b. Case management is provided as needed,
   c. Behavioral Health service plans identify transportation the parents and child need to access Behavioral Health Services, and how transportation assistance will be provided, and
   d. Behavioral Health Services are adapted or created when they are needed but not available.
5. **Best practices:**
   a. Behavioral Health Services are provided by competent individuals who are trained and supervised,
   b. Behavioral Health Services are delivered in accordance with guidelines that incorporate evidence-based "best practices,"
   c. Behavioral Health service plans identify and appropriately address behavioral symptoms that are related to: learning disorders, substance use problems, specialized behavioral health needs of children who are developmentally disabled, history of trauma (e.g. abuse or neglect) or traumatic events (e.g death of a family member or natural disaster), maladaptive sexual behavior, abusive conduct and risky behaviors. Service plans shall also address the need for stability and promotion of permanency in class members' lives, especially class members in foster care, and
   d. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. **Most appropriate setting:**
   a. Children are provided Behavioral Health Services in their home and community to the extent possible, and
   b. Behavioral Health Services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. **Timeliness:**
   a. Children identified as needing Behavioral Health Services are assessed and served promptly.
8. **Services tailored to the child and family:**
   a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of Behavioral Health Services provided, and
   b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. **Stability:**
   a. Behavioral Health service plans strive to minimize multiple placements,
   b. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,
   c. Behavioral Health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,
   d. In responding to crises, the Behavioral Health system uses all appropriate Behavioral Health Services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and
   e. Behavioral Health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. **Respect for the child and family's unique cultural heritage:**
    a. Behavioral Health Services are provided in a manner that respects the cultural tradition and heritage of the child and family, and
    b. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. **Independence:**
    a. Behavioral Health Services include support and training for parents in meeting their child's Behavioral Health needs, and support and training for children in self-management, and
    b. Behavioral Health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
12. **Connection to natural supports:**
    a. The Behavioral Health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Nine guiding principles for recovery-oriented adult Behavioral Health Services and systems

1. **Respect.**
   Respect is the cornerstone. Meet the individual where they are without judgment, with great patience and compassion.
2. **Individuals in recovery choose services and are included in program decisions and program development efforts.**
   An individual in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. **Focus on individual as a whole person, while including and/or developing natural supports.**
   An individual in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. **Empower individuals taking steps toward independence and allowing risk taking without fear of failure.**
   An individual in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. **Integration, collaboration, and participation with the community of one's choice.**
   An individual in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. **Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust.**
   An individual in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. **Individuals in recovery define their own success.**
   An individual in recovery — by their own declaration — discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Individuals in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. **Strengths-based, flexible, responsive services reflective of an individual's cultural preferences.**
   An individual in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores.
   An individual in recovery is the source of their own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
9. **Hope is the foundation for the journey toward recovery.**
   An individual in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. An individual in recovery is held as boundless in potential and possibility.

Multi-Specialty Interdisciplinary Clinics

Multi-Specialty Interdisciplinary Clinics (MSICs) are clinics where members under the age of 21 can see their medical specialists and any others involved in their care, all at one location. When CRS Designated members turn 21 they will no longer be designated as CRS. However, may continue to receive care at the MSIC. All members can be seen at the MSIC, not just those with a CRS diagnosis. At the MSIC, you and your family can meet face-to-face with the members of your team of providers to get medical care, plan your treatment, and receive other services that meet your unique needs. Each MSIC is open from the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday. Specific clinics, such as the cardiac clinic, may be held on certain days and times. Contact your MSIC for a schedule of clinics. To make, change or cancel appointments at the MSIC, contact the MSIC at the clinic phone number listed below.

Medical providers on your team could be:

Surgeons

- General pediatric surgeons
- Cardiovascular and thoracic surgeons
- Ear, Nose and Throat (ENT) surgeons
- Neurosurgeons
- Ophthalmology surgeon
- Orthopedic surgeons (general, hand, scoliosis, amputee)
- Plastic surgeons

Medical specialists

- Cardiologists
- Neurologists
- Rheumatologists
- General Pediatricians
- Geneticists
- Urologists
- Metabolocists

Dental providers

- Dentists
- Orthodontists

CRS MSICs are at the following locations:

DMG Children's Rehabilitative Services
3141 North 3rd Avenue, Suite 100
Phoenix, AZ 85013
602-914-1520

Children's Clinics
Square & Compass Building
2600 North Wyatt Drive
Tucson, AZ 85712
520-324-5437, 800-231-8261

Children's Health Center
5130 N Highway 89A
Flagstaff, AZ 86004
928-773-2054, 800-232-1018

Children's Rehabilitative Services
2851 South Avenue B
Building 25
Yuma, AZ 85364
928-336-2777, 800-837-7309

Children's Rehabilitative Services (CRS)

What is CRS?

Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS and DDD members who have qualifying health conditions. Members with a CRS designation can get the same AHCCCS covered services as non-CRS AHCCCS members and are able to get care in the community, or in clinics called multispecialty interdisciplinary clinics (MSIC). MSICs bring many specialty providers together in one location. Your health plan will assist a member with a CRS designation with closer care coordination and monitoring to make sure special health care needs are met.

Eligibility for a CRS designation is determined by the AHCCCS Division of Member Services (DMS).

Who is eligible for a CRS designation?

AHCCCS members may be eligible for a CRS designation when they are:

- Under age 21; and
- Have a qualifying CRS medical condition.

The medical condition must:

- Require active treatment; and
- Be found by AHCCCS DMS to meet criteria as specified in A.A.C. R9-22-1303.

Anyone can fill out a CRS application including a family member, doctor, or health plan representative. The CRS Unit can also help with completing the application. You can contact the CRS Unit at: 602-417-4545.

For more information visit:
https://www.azahcccs.gov/PlansProviders/CurrentProviders/CRSreferrals.html

To apply for a CRS designation mail or fax:

- A completed CRS application; and
- Medical documentation that supports that the applicant has a CRS qualifying condition that requires active treatment.

UnitedHealthcare Community Plan will provide medically necessary care for physical and behavioral health services and care for the CRS condition.

Member Council

UnitedHealthcare Community Plan Long Term Care Advocacy Councils provide a forum for Health Plan Members, local Long Term Care providers and local community agencies to give recommendations about Long Term Care services. At meetings we discuss new and ongoing AHCCCS programs. It is a great opportunity for Members to provide input about current processes and future changes to the ALTCS program. We talk about how to improve care for our members. Any Health Plan member can go to meetings. We would like you to be a part of our Long Term Care Member Advisory Council.

Meetings are held quarterly. If you are interested in joining the Member Advisory Council speak with your Case Manager or contact Member Services by calling **1-800-293-3740** and ask to speak with a representative from the Long Term Care program.

Utilization Management policy and procedures

We have policies and steps we follow in decision-making about approving medical services. We want to make sure that the health care services provided are medically necessary, right for your condition and are provided in the best care facility. We make sure that quality care is delivered.

The criteria used in our decision-making are available to you and your doctor if you ask for it. No UnitedHealthcare Community Plan employee or provider is rewarded in any way for not giving you the care or services you need or for saying that you should not get them.

A Utilization Management (UM) Decision is when we look at the appropriateness, medical need and efficiency of health care services, procedures and facilities against our set criteria. Included may be: discharge planning, concurrent planning, pre-certification, approval in advance and clinical case appeals. Also, it may cover proactive processes like concurrent clinical review, peer review and appeals from a provider, payer or patient/member. A service shall be considered medically necessary if it prevents, diagnoses, or treats a physical or behavioral health condition or injury, is necessary to achieve age appropriate growth and development, minimizes the progression of disability, or is necessary to attain, maintain, or regain functional capacity.

There are also some treatments and procedures we need to review before you can get them. Your providers know what they are, and they take care of letting us know to review them. The review we do is called a Utilization Review. We do not reward anyone for saying no to needed care. If you have questions about UM, you can talk to our Medicaid Care Management staff. Our nurses are available 24 hours per day/7 days a week by calling 1-877-440-0255, TTY/TDD 1-800-855-2880. Language assistance is available.

Preauthorization process

How will I know if a service has been approved (authorization) or denied?

UnitedHealthcare Community Plan reviews a service request from you, your PCP, or your specialist. This includes Behavioral Health residential facilities, therapeutic foster care, and skilled nursing facilities. You can make a service request by calling Member Services. Your doctor will tell you if the service is approved. If the service has been denied, UnitedHealthcare Community Plan will send you and your provider a letter, called a Notice of Adverse Benefit Determination. You have a right to know the criteria that are used to make decisions. Normal authorization decisions will be made within 14 calendar days from the date the request is received.

Extensions of up to 14 calendar days can be received if it is in your best interest. For example, we may be waiting to receive your medical records from your doctor. Instead of making a decision without those records, we may ask you if it's okay to get more time to receive the records. That way, the decision can be made with the best information. We will send you a letter asking for the extension.

Expedited (Rush) decisions in urgent, life-threatening situations should be made in no later than 72 hours following the receipt of the authorization request unless an extension is in effect. For more information, call Member Services on Notice of Adverse Benefit Determination letters and actions you can take.

Call Member Services for more information about filing an appeal

If you have questions, ask your Case Manager or contact Member Services at **1-800-293-3740**, TTY **711**, or visit our website: **UHCCommunityPlan.com**.

Prior approval for an out-of-network provider

UnitedHealthcare Community Plan is a managed care plan. You should use the providers in our contracted network. However, there may be times when you need care from a provider that's not in our network. Your PCP or treating physician may request for you to see an out-of-network provider by calling UnitedHealthcare Community Plan: **1-800-293-3740**, TTY/TDD **711**. The out-of-network provider must be registered with AHCCCS and must obtain an authorization for services. Services will be at no cost to you when UnitedHealthcare Community Plan authorizes the care or service in advance, before you see the provider.

Prior authorization medication

Some medications may require prior-authorization. Prior-authorization decisions for medications will be made within 24 hours from the receipt of the request. If additional information is needed, UnitedHealthcare will send a request to your provider and issue a final decision no later than 7 working days from the date of the request. Please see UnitedHealthcare's drug list at **UHCCommunityPlan.com**.

Freedom of choice

A provider network is a group of providers who contract with UnitedHealthcare Community Plan to provide services. Your Case Manager will help you choose providers from within its provider network. If you'd like to select a provider based on convenience, location or cultural preference, you can tell your Case Manager.

If our provider network is unable to provide medically necessary services required that you need, then these services can be covered through an out-of-network provider until a network provider is contracted.

Members can also choose their own family planning provider using the provider directory on our website, or you may choose a provider who is not in our network of providers.

If you choose a provider not in our network, the provider will need to obtain prior authorization for services.

All out-of-network providers must also be registered with AHCCCS.

Copayments

ALTCS members do not have to pay any Medicaid copayments to providers.

Member share of cost

People who are enrolled in Arizona Long Term Care System (ALTCS) are not asked to pay copayments as applicable. This applies to copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

Under ALTCS, you may pay for part of the cost of your services. If you have a monthly income, ALTCS will figure how much you need to pay. If you are living in a nursing facility, you pay your "share of cost" to the facility. ALTCS will tell you your "Member share of cost." You may ask your ALTCS Eligibility Worker for these amounts at any time.

If you live in the community, you may have a share of cost, payable to UnitedHealthcare Community Plan.

If you are in an assisted living facility, you must pay for your room and board. You pay this directly to your facility. Federal regulation does not allow AHCCCS/ALTCS to pay room and board in an Alternative Home and Community Based Service (HCBS) settings. Your Case Manager will tell you what your room and board will be during the initial assessment period or prior to or on the day that you move into an Alternative HCBS setting. Your Case Manager will complete a Residency Agreement, which will indicate the amount to be paid monthly to the facility. The member, health care decision maker or designated representatives and Alternative HCBS provider will receive a copy.

Can a provider bill me?

I received a bill for medical services, or my doctor wants a copay

Tell your provider you are an ALTCS member. Show them your ID card. You do not have to pay bills or copays for any service covered by ALTCS from AHCCCS registered providers. The provider is not allowed to bill you. If you do get a bill, call the provider and tell them to stop billing you and to send a claim to UnitedHealthcare Community Plan.

When can members be billed for benefits that are not covered by AHCCCS?

If you agree to receive services that are not covered by UnitedHealthcare Community Plan or agree to receive services that are in excess of what is allowed by the plan, you may have to pay the bill.

AHCCCS allows a provider to charge a member if:

1. The member requests a benefit that is not covered or not authorized by the health plan or AHCCCS; and
2. The provider provides the member with a document describing the benefits and the approximate cost; and
3. The member signs the document prior to getting the benefits, showing that the member understands and accepts responsibility for payment.

Medicare or other insurance

It is important to tell us if you have other insurance or Medicare. It does not change any of the services or benefits you get from UnitedHealthcare Community Plan. Try to choose a PCP who works with both UnitedHealthcare Community Plan and your other insurance. This will help us coordinate your benefits.

Members who have both ALTCS and Medicare are called "dual eligible." UnitedHealthcare Community Plan may help pay your coinsurance and deductibles if you use Medicare providers that are also contracted with UnitedHealthcare Community Plan or who follow all of UnitedHealthcare Community Plan's cost-sharing rules.

Always tell your doctor if you have other insurance. Your other insurance or Medicare is considered your primary insurance. They may pay for your medical services. You must use your primary insurance plan first. UnitedHealthcare Community Plan is your secondary insurance. UnitedHealthcare Community Plan may help you pay copays, coinsurance or deductibles that other insurance may charge you.

Do not pay the doctor directly. If you pay for AHCCCS-covered services directly, we cannot pay you back. **Tell your doctor to bill UnitedHealthcare Community Plan.** Make sure to show the doctor your UnitedHealthcare Community Plan ID card and your other insurance. This will help them to know where to send the bill. If you do not tell your doctor that you have other insurance, this may delay payment from UnitedHealthcare Community Plan.

Your Case Manager will help you manage benefits. Make sure your Case Manager has all of your insurance information.

ALTCS benefits will not change your Medicare benefits. If you are dually eligible, you need to know that:

- If you have Traditional Medicare, your doctor may be registered with AHCCCS
- If you see a doctor who is not with AHCCCS, you may have to pay your copay and deductible
- If you are in a Medicare HMO/Advantage plan, your PCP will be the one from your Medicare HMO. You do not have to get another PCP for ALTCS.

Coordination of benefits/third party liability

Your Medicaid benefits under AHCCCS are the payer of last resort. That means they will pay only after all other sources/insurance have been used. UnitedHealthcare Community Plan may help you pay copays, coinsurance or deductibles that other insurance may charge you.

Medicare prescription drug benefit and AHCCCS members

AHCCCS covers drugs which are medically necessary, cost-effective, and allowed by federal and state law.

- Medicare, instead of AHCCCS, offers drug coverage. AHCCCS will still pay for your other covered health care costs.
- Medicare drug coverage is available to all qualifying people with Medicare
- You must join and stay in a drug plan for Medicare to pay for your drugs
- You are eligible for extra help with Medicare costs under Social Security's Extra Help
- Medicare drug coverage is set up to pay for brand name and generic drugs
- You can switch to another drug plan at any time
- UnitedHealthcare Community Plan pays for some drugs not covered by Medicare. Drugs covered by UnitedHealthcare Community Plan do not have a copay.
- UnitedHealthcare Community Plan works with many pharmacies. Some are open 24 hours a day. If the pharmacy tells you a drug is not covered, ask them to contact the Pharmacy Benefits Manager.

More information is at **UHCCommunityPlan.com**.

AHCCCS covers drugs which are medically necessary, cost-effective, and allowed by federal and state law.

Medicaid does not cover medications that are eligible for coverage under Medicare Part D plans. Medicaid does not pay for Medicare copayments, deductibles or cost sharing for Medicare Part D medications except for persons who have an SMI designation. AHCCCS covers medications that are excluded from coverage under Medicare Part D when those covered medications are deemed medically necessary. An excluded drug is a medication that is not eligible for coverage under Medicare Part D. AHCCCS may cover some medications that are Over-the-Counter (OTC), refer to the UnitedHealthcare OTC Drug List for a list of products available on our website at **UHCCommunityPlan.com** or call Member Services to request a printed copy.

Quality of Care concerns

Members/Health Care Decision Makers (HCDMs) can submit concerns that include but are not limited to:

- The inability to receive health care services,
- Concerns about the Quality of Care (QOC) received,
- Issues with health care providers,
- Issues with health plans, or
- Timely access to services.

Quality of concern issues may be submitted by calling Case Manager or Member Services at **1-800-293-3740**.

Member grievances (complaints) and appeals not related to a Serious Mental Illness (SMI) reason

If you have a problem or complaint about UnitedHealthcare Community Plan, ask your Case Manager or Member Services for help. You may file a grievance at any time. If your Case Manager or Member Services is able to help you, your complaint will be considered resolved. In that case, you will not get any other notice.

If you are not happy with the response from your Case Manager or Member Services, you may file a grievance. You may file a complaint or grievance against us (the managed care organization) or a provider with us.

Members can file a grievance orally with their Case Manager or call Member Services from 8:00 a.m. to 5:00 p.m., Monday through Friday, at **1-800-293-3740**, TTY **711**. All members can file a grievance through this process. Members designated with a Serious Mental Illness have a different grievance process in the next section if their grievance is related to rights, abuse, or mistreatment for behavioral health services. Please follow that process.

Members may also file a written grievance by sending it to:

UnitedHealthcare Community Plan
Attn: Grievance and Appeals
1 East Washington, Suite 900
Phoenix, AZ 85004

UnitedHealthcare Community Plan will let you know when we receive your grievance and we will look into the problem and decide what to do. If your provider has your written permission they can file a grievance on your behalf.

Most grievances are resolved within 10 working days but not more than 90 calendar days.

If you need help filing a grievance including the need for language translation or interpreter services for a hearing or vision impairment, contact your Case Manager or call Member Services at **1-800-293-3740**, TTY **711**. Grievance information is available in alternative formats.

To file a grievance, an appeal, or to request a hearing with a RBHA regarding crisis services provided by the RBHA please call the RBHA directly:

Maricopa County served by Mercy Care:
1-800-631-1314 or 602-222-9444

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties served by Arizona Complete Health – Complete Care Plan:
1-866-495-6735

Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties served by Health Choice Arizona:
1-877-756-4090

Grievances/requests for investigation for a Serious Mental Illness (SMI) reason

The SMI Grievance/Request for Investigation process applies only to adult persons who have been determined to have a serious mental illness and to any behavioral health services received by the member.

You can file a Grievance/Request for Investigation if you feel:

- Your rights have been violated
- You have been abused or mistreated by staff of a provider
- You have been subjected to a dangerous, illegal, or inhuman treatment environment

You have 12 months from the time that the rights violation happened to file an SMI Grievance/Request for Investigation having to do with any behavioral services that you received. You may file a Grievance/Request for Investigation orally or in writing. Grievance/Request for Investigation forms are available at UnitedHealthcare Community Plan and providers of behavioral health services. You may ask staff for help in filing your grievance.

Contact Member Services at **1-800-293-3740**, TTY **711** or your Case Manager to make your oral or written Grievance/Request for Investigation.

To file a written Grievance/Request for Investigation directly, mail to:

UnitedHealthcare Community Plan
Attn: Member Grievance and Appeals
1 East Washington Street, Suite 900
Phoenix, AZ 85004

UnitedHealthcare will send you a letter within 5 working days of receiving your Grievance/Request for Investigation. This letter will tell you how your Grievance/Request for Investigation will be handled.

Grievances concerning physical abuse, sexual abuse or a person's death are investigated by AHCCCS. To file an oral or written grievance concerning physical abuse, sexual abuse or a person's death, contact AHCCCS no later than 12 months from the date of the alleged violation or condition requiring investigation occurred. Contact:

AHCCCS Office of Grievance and Appeals
801 E. Jefferson St., MD6200
Phoenix, AZ 85034

Or call 602-364-4575
or fax 602-364-4591

Deaf or hard-of-hearing individuals may call the Arizona Relay Service at 711 or 1-800-367-8939 for help contacting AHCCCS.

AHCCCS will send you a letter within 5 working days of getting your Grievance/Request for Investigation. This letter will tell you how your Grievance/Request for Investigation will be handled.

If there will be an investigation, the letter will tell you the name of the investigator. The investigator will contact you to hear more about your Grievance/Request for Investigation. The investigator will then contact the person that you feel was responsible for violating your rights. The investigator will also gather any other information they need to determine if your rights were violated.

You will get a written decision of the findings, conclusions and recommendations of the investigation. You will also be told if you have the right to appeal the decision if you do not agree with the conclusions of the investigation.

If you file a Grievance/Request for Investigation, the quality of your care will not suffer.

Notice of adverse benefit determination

An adverse benefit determination is when UnitedHealthcare Community Plan does any of the following:

- Denies or limits a requested service based on type or level of service, meeting medical necessity, appropriateness, setting, effectiveness
- Reduces, suspends, or terminates a previously authorized service
- Denies partial or full payment of a service
- Fails to make an authorization decision or to provide services in a timely manner
- Fails to resolve a grievance or appeal in a timely manner
- Denies a rural member's request for services outside the network when the health plan is the only one in the area

If UnitedHealthcare Community Plan makes an adverse benefit determination, you will receive a letter called a Notice of Adverse Benefit Determination. This letter will tell you:

- What was asked for
- What action was taken and why
- Your right to file an appeal, ask for a State Fair Hearing, or ask for an expedited resolution
- If you were receiving benefits, your right to have your benefits continue during your appeal and how to do it

If you do not understand your Notice of Adverse Benefit Determination, call Member Services. You have a right to know the criteria that are used to make decisions. You can also file a grievance if you do not feel the letter was clear enough for you. If you are still not happy about the notice, you may contact AHCCCS by email **MedicalManagement@azahcccs.gov**.

Member appeals

Appeals not related to a Serious Mental Illness (SMI)

If you do not agree with a decision made by UnitedHealthcare Community Plan you can ask us to review the request again. This request for a review is called an appeal. The appeal can be written or verbal. If you want to file a verbal appeal, call Member Services, **1-800-293-3740**, TTY **711**.

UnitedHealthcare Community Plan will provide assistance to you in completing forms and taking other procedural steps related to filing an appeal. If you need help filing an appeal, including the need for language translation or interpreter services for a hearing or vision impairment, contact your Case Manager or call Member Services at **1-800-293-3740**, TTY **711**. Appeal information is available in alternative formats. Your provider or family, health care decision maker or designated representative can also file an appeal on your behalf with your written permission. You or your family, health care decision maker or designated representative must file an appeal within 60 days from the date of the notice letter. You or your provider can't be retaliated against for filing an appeal. This means UnitedHealthcare Community Plan will not be upset at you or your provider or attempt to get back at either of you for filing an appeal.

Send your written appeal to:

UnitedHealthcare Community Plan
Attn: Member Grievance and Appeals
1 East Washington Street, Suite 900
Phoenix, AZ 85004

When UnitedHealthcare Community Plan gets your appeal, we will send you a letter telling you that we received your appeal. If you want to continue your services during the appeal process, you must tell us no later than 10 calendar days from the date of the Notice of Adverse Benefit Determination letter. If AHCCCS agrees with UnitedHealthcare Community Plan's decision, you may have to pay for these services.

UnitedHealthcare Community Plan will make every effort to investigate your appeal within 30 calendar days. You may ask for a quicker decision. This is known a an expedited appeal. If your doctor or UnitedHealthcare Community Plan feels that your appeal should be reviewed more quickly due to the seriousness of your condition, you will receive a decision about your appeal within 72 hours. If your appeal does not need an expedited review, we will try to call you and within 2 calendar days and will send you a letter letting you know that your appeal will be reviewed within 30 calendar days. The letter will explain how to file a grievance if you don't agree with our decision to take more time.

The appeal process may take up to 14 calendar days longer if you ask for more time to submit information or UnitedHealthcare Community Plan needs to get additional information from other sources. If we need additional information, we will call and send you a letter within 2 calendar days. The letter will explain how to file a grievance if you don't agree with our decision to take more time.

When UnitedHealthcare Community Plan decides your appeal, we will mail a Notice of Appeal Resolution letter to you. This letter will tell you the reason for the decision. If UnitedHealthcare Community Plan decides that you should not receive the denied service, the letter will also tell you how to ask for a State Fair Hearing and, if you were receiving benefits, your right to have your benefits continue during your State Fair Hearing and how to do it.

You or your provider can't be retaliated against for filing an expedited appeal. This means UnitedHealthcare Community Plan will not be upset at you or your provider or attempt to get back at either of you for filing an expedited appeal.

State Fair Hearing

If you do not agree with UnitedHealthcare Community Plan's decision on your appeal, you can request a State Fair Hearing. Your request for a State Fair Hearing must be in writing and received within 90 calendar days from the date you receive the appeal resolution letter.

AHCCCS will send you information on how your State Fair Hearing will be handled. The AHCCCS Administration will decide if UnitedHealthcare Community Plan's decision was correct. If AHCCCS decides that UnitedHealthcare Community Plan's decision was correct, you may have to pay for services you received during the State Fair Hearing. If AHCCCS decides that UnitedHealthcare Community Plan's decision was not correct, UnitedHealthcare Community Plan will authorize and pay for services promptly.

Appeals for SMI determination

A serious mental illness (SMI) is a mental disorder in persons 17 and a half years of age or older that's severe and persistent. Solari Crisis & Human Services, a provider that has a contract with AHCCCS, will make a determination of serious mental illness upon referral or request.

Members asking for a determination of serious mental illness and members who have been determined to have a serious mental illness can appeal the result of a serious mental illness determination.

Solari Crisis & Human Services will send you a letter by mail to let you know the final decision on your SMI determination. This letter is called a Notice of Decision. The letter will include information about your rights and how to appeal the decision. To file an appeal, you can call Solari Crisis & Human Services at 1-855-832-2866.

SMI behavioral health appeals

Any person, age 18 or older, his or her guardian, or designated representative, may file an appeal related to services applied for or services the person is receiving. Matters of appeal are generally related to:

- Denial of services
- Disagreement with the findings of an evaluation or assessment with any part of the Individual Service Plan, the Individual Treatment and Discharge Plan
- Recommended services or actual services provided
- Denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title XIX/XXI funds. Persons determined to have a serious mental illness cannot appeal a decision to deny, suspend or terminate services that are no longer available due to a reduction in State funding.
- Decision regarding fees or waivers
- Capacity to make decisions, need for guardianship or other protective services or need for special assistance

Appeals must be filed with UnitedHealthcare Community Plan and must be initiated no later than 60 days after the decision or action being appealed. Appeal forms are available through UnitedHealthcare Community Plan, AHCCCS, your Case Manager, and at all provider sites.

UnitedHealthcare Community Plan will attempt to resolve all appeals within 7 days through an informal process. If the issue cannot be resolved, the matter will be forwarded for further appeal. You may request an Administrative Review by AHCCCS.

For SMI grievances/requests for investigation and appeals please include:

- Name of person filing the SMI grievance/request for investigation or appeal
- Name of the person receiving services, if different
- Mailing address and phone number
- Date of issue being appealed or incident requiring investigation
- Brief description of issue or incident
- Resolution or solution desired

You may represent yourself, designate a representative, or use legal counsel.

You may contact the State Protection and Advocacy System, the Arizona Center for Disability Law 1-800-922-1447 in Tucson and 1-800-927-2260 in Phoenix. You may also contact the Office of Human Rights at 602-364-4585, or 1-800-421-2124 for assistance. If your complaint relates to a licensed behavioral health agency, you may contact the Office of Behavioral Health Licensure, 150 N. 18th Avenue, Phoenix, Arizona 85007, 602-364-2595.

UnitedHealthcare Community Plan will provide assistance to you in completing forms and taking other procedural steps related to filing an appeal. If you need help filing an appeal, including the need for language translation or interpreter services for a hearing or vision impairment, contact your Case Manager or call Member Services at **1-800-293-3740**, TTY **711**. Appeal information is available in alternative formats. Your provider or family, health care decision maker or designated representative can also file an appeal on your behalf with your written permission. You or your provider can't be retaliated against for filing an appeal. This means UnitedHealthcare Community Plan will not be upset at you or your provider or attempt to get back at either of you for filing an appeal. Appeals can be submitted in writing or verbally to UnitedHealthcare. If you want to file a verbal appeal, call Member Services, **1-800-293-3740**, TTY **711**.

Send your written appeal to:

UnitedHealthcare Community Plan
Attn: Member Grievance and Appeals
1 East Washington Street, Suite 900
Phoenix, AZ 85004

What happens after I file an SMI behavioral health appeal?

If you file an appeal, you will get written notice that your appeal was received within 5 working days of UnitedHealthcare Community Plan's receipt. You will have an informal conference with UnitedHealthcare Community Plan within 7 working days of filing the appeal. The informal conference must happen at a time and place that is convenient for you. You have the right to have a designated representative of your choice assist you at the conference. You and any other participants will be informed of the time and location of the conference in writing at least 2 working days before the conference. You can participate in the conference over the telephone.

For an appeal that needs to be expedited, you will get written notice that your appeal was received within 1 working day of UnitedHealthcare Community Plan's receipt, and the informal conference must occur within 2 working days of filing the appeal.

If the appeal is resolved to your satisfaction at the informal conference, you will get a written notice that describes the reason for the appeal, the issues involved, the resolution achieved and the date that the resolution will be implemented. If there is no resolution of the appeal during this informal conference, the next step is a second informal conference with AHCCCS. You may waive the second level informal conference and proceed to a State Fair Hearing, however. If you waive the second level informal conference with AHCCCS, UnitedHealthcare Community Plan will assist you in filing a request for State Fair Hearing at the conclusion of the UnitedHealthcare Community Plan informal conference.

If there is no resolution of the appeal during the second informal conference with AHCCCS, you will be given information that will tell you how to get a State Fair Hearing. The Office of Grievance and Appeals at AHCCCS handles requests for State Fair Hearings upon the conclusion of second level informal conferences.

Will my services continue during the SMI behavioral health appeal process?

If you file an appeal, you will continue to get any services you were already getting unless a qualified clinician decides that reducing or terminating services is best for you, or you agree in writing to reducing or terminating services.

Questions and answers on appeals

Q: What if I need help in filing an appeal or need an interpreter?

A: If you need help in filing a grievance because you do not speak English and need an interpreter, or have a hearing or vision impairment, contact your Case Manager or call Member Services at **1-800-293-3740**, TTY **711**.

Q: How do I file an appeal?

A: You may file an appeal over the phone or in writing. All letters of appeal must be sent to:

UnitedHealthcare Community Plan Appeal Manager
1 East Washington, Suite 900
Phoenix, AZ 85004

Or call Member Services at **1-800-293-3740**, TTY **711**.

You may file a complaint or grievance against us (the managed care organization) or a provider with us. Refer to the Member Grievance Process for details on filing.

Member rights

You have the right to:

- File a complaint or an appeal about your health plan. This complaint may be filed with UHCCP or you may contact AHCCCS by email **MedicalManagement@azahcccs.gov**.
- Request information on the structure and operation of the health plan or its subcontractors
- Ask UnitedHealthcare Community Plan about any Physician Incentive Plans that affect the use of referral services
- Know the types of compensation arrangements the health plan uses
- Know whether stop loss insurance is needed
- Get member survey summaries
- Be treated fairly regardless of your race, ethnicity, national origin, religion, gender, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or ability to pay
- Be examined with privacy
- Talk about your medical care in private
- Have your medical records read only by people involved in your care or if you give specific permission
- Have records about your care, including your being in ALTCS, kept private
- Know that at times the health plan may coordinate care with schools and state agencies as allowed
- Request a second opinion from a qualified health care professional within UnitedHealthcare Community Plan's network at no cost to you. A second opinion may be received from an out-of-network provider, at no cost to you, if there is no in-network coverage.
- Get information from your doctor on your diagnosis, care and possible outcome(s)
- Get information on treatment options regardless of cost or benefit coverage in a format you can understand or that your Case Manager will explain
- Develop contingency planning with your provider agency to decide your preferences when a scheduled caregiver visit is late, missed, or short
- Provided with information on how to set up Advance Directives
- Request your medical records or child's medical records annually at no cost to you as allowed by law and receive a response within 30 days to your request for a copy of the medical records. The response may be the copy of the medical record or a written denial that includes the basis for the denial and information about how to seek review of the denial in accordance with 45 CFR Part 164.

- To request your medical record be amended or corrected as allowed by law
- To be free from restraint or seclusion as coercion, discipline, convenience, or retaliation, per federal law
- Receive information about your benefits and health plan, practitioners and providers, and member rights and responsibilities
- Receive information on beneficiary or plan information
- You will be treated with respect and due consideration for your dignity and privacy
- Participate in decisions regarding your health care, including the right to refuse treatment
- Know the languages spoken by each contracted UnitedHealthcare Community Plan doctor
- Get a list of our providers at no charge that shows what languages the doctors speak. Call Member Services at **1-800-293-3740**, TTY **711** or your Case Manager for a listing.
- Go to any hospital or other setting for emergency care
- Receive notification when assigned PCP or frequently used provider leaves the network
- Make recommendations regarding the organization's member rights and responsibility policy
- Individuals receiving HCBS services have the right to be integrated into their communities and have full access to the benefits of community living
- Request information on whether or not UnitedHealthcare Community Plan has Physician Incentive Plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements UnitedHealthcare Community Plan uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation

Electronic Visit Verification (EVV)

EVV is a computer-based system that electronically verifies the occurrence of authorized service visits be electronically documenting the exact time a service delivery visit begins and ends, the individuals receiving and providing a service, and the type of service performed.

We are using EVV to verify personal care and home health services to make sure you get the services that you need when you need them. EVV is a technology-based verification system for authorized services that electronically documents the exact times a service delivery visit begins and ends, the individuals receiving and providing a service, and the type of service performed.

The EVV system is designed to support how you manage your care including scheduling your services and monitoring your service hours. EVV is designed for you and works wherever your in-home services take place. You have the option to choose which device is used to verify that you have received a service. These services may be provided by different provider agencies, including:

- Attendant care
- Personal care
- Homemaker
- Daily living skills
- Home health
- Respite care
- Therapy
- Companion care

The EVV system electronically verifies the:

- Service type
- Member
- Date of service
- Service location
- Provider
- Service times (start and end)

What stays the same	What will change
Members have choice of provider	Paper time sheet will be eliminated
Availability of services	EVV device will be used to verify service delivery
Members have choice of individual direct care worker	How member/health care decision maker or designated representative signature is collected
How services are provided	Verification will be required by member/health care decision maker or designated representative at the end of every visit/shift
Where services are provided	

EVV is designed for you:

- EVV works wherever services take place, whether at home or in the community
- EVV supports case management, including the scheduling and monitoring of service hours
- Members have the option to choose what device they want to use to verify that service has been received
- Members can decide how quickly a replacement caregiver will be needed if the scheduled caregiver is late or no-shows

For questions, contact Member Services at **1-800-293-3740**, TTY **711**. For additional information, including the list of services subject to EVV, visit: **https://azahcccs.gov/EVV**.

Immunizations (shots)

Immunizations (shots) can keep you and your child from getting sick in the future. Talk with your child's PCP about the immunizations that are needed and when they are needed. The best place for children to get their immunizations is at their PCP's office. You should use an immunization schedule and have the schedule updated when you visit your child's doctor.

Here are the essentials to know about each of these vaccines.

COVID-19 protects against the COVID-19 virus.

DTaP protects against diphtheria, tetanus, and pertussis (whooping cough). It requires five doses during infancy and childhood. DTaP boosters are then given during adolescence and adulthood.

HepA protects against hepatitis A. This is given as two doses between 1 and 2 years of age.

HepB protects against hepatitis B (infection of the liver). HepB is given in three shots. The first shot is given at the time of birth.

Hib protects against Haemophilus influenzae type b. This infection used to be a leading cause of bacterial meningitis. Hib vaccination is given in three or four doses.

HPV protects against cancers caused by Human papillomavirus. Children 11 or 12 years of age should get two shots of HPV, six to 12 months apart.

Influenza (flu) protects against the flu. This is a seasonal vaccine that is given yearly. Flu shots can be given to your child each year, starting at age 6 months. Flu season can run from September through May.

IPV protects against polio and is given in four doses.

Meningococcal protects against the bacteria that causes meningococcal disease. Children should get this vaccine at 11 or 12 years of age.

MMR protects against measles, mumps, and rubella (German measles). MMR is given in two doses. The first dose is recommended for infants between 12 and 15 months. The second dose is usually given between ages 4 and 6 years. However, it can be given as soon as 28 days after the first dose.

PCV protects against pneumococcal disease, which includes pneumonia. PCV is given in a series of four doses.

RV protects against rotavirus, a major cause of diarrhea. RV is given in two or three doses, depending on the vaccine used.

Tdap protects your child from diphtheria, tetanus and whooping cough. Children should get this vaccine at 11 or 12 years of age.

Varicella protects against chickenpox. Varicella is recommended for all healthy children. It's given in two doses.

Adult care

Getting care early may help your doctor find and treat health problems and keep you healthy. Follow the schedule below for your wellness care. Your PCP will also give you tips to stay healthy, like eating right and exercising regularly.

Adult care schedule

Type of service	18–64 years old	65 years old and over
Blood pressure check	Every year (additional tests based on your health history)	Every year (additional tests based on your health history)
Breast exam	Every year	Every year
Cholesterol check	Once (additional tests based on history)	Based on history
Colorectal cancer	Every year from age 45	Every year

Type of service	18–64 years old	65 years old and over
Flu vaccine	Every year	Every year
Health education	Every doctor visit	Every doctor visit
HIV screening	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Immunizations (shots)	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Mammogram	Every year for age 40 and over or based on medical need	Every year
Pap smear	Pap smears covered beginning at 21 years of age. Discuss with your provider regarding frequency.	See your PCP or OB/GYN
Physical exam (unclothed)	Every year	Every year
Pneumonia vaccine	Under age 65 covered for certain conditions. Check with your provider.	Once on or after age 65
Prostate screening	Every year after age 50 (additional tests based on your health history)	Every year
Sexually Transmitted Disease screening	At least once during pregnancy (additional tests based on your health history)	Ask your doctor if you are at risk
Tdap (tetanus/diphtheria/ acellular pertussis)	Every 10 years	Every 10 years
Testicular exam	Every 2 years from age 18–39	Not required
Tuberculosis screening	Once (additional tests based on your health history)	Ask your doctor if you are at risk

These are general guidelines. Your PCP may want you to get these services more or less often.

Your right for an Advance Directive

All patients in hospitals, nursing centers, and other health care settings have rights. You have the right to have your personal and medical records kept private. You have the right to know what treatment you will get.

Per federal law, you have the right to make an **"Advance Directive."** This is a document that says in advance what treatment you want or do not want. This is useful when you can't tell medical staff your wishes. This section will help explain this law. It requires hospitals, nursing centers, and other providers to tell you about Advance Directives. It outlines your choices in making decisions about medical care. The law increases your control over treatment decisions.

Some helpful websites are:

Arizona Attorney General's Life Care Planning site at: **https://www.azag.gov/seniors/life-care-planning**. The Arizona Advance Directive Registry is a free registry you can use to electronically store and access your medical directives. Their secure and confidential program grants peace of mind to registrants and their families, and easy access to all health care providers. For more information visit: Arizona Health Information Exchange at: **https://healthcurrent.org/azhdr**.

The Advance Directive Registry has been moved from the Arizona Secretary of State's Office to Health Current, Arizona's Health Information Exchange site.

Q: What is an Advance Directive?

A: It is a written statement about how you want your health decisions made. Under Arizona law, there are three common types. These are:

1. A Health Care Power of Attorney.
2. A Mental Health Power of Attorney
3. A Living Will.
4. Pre-Hospital Medical Care Directive.

1. **A Health Care Power of Attorney** — is a legal document where you name an adult to make health care decisions for you when you cannot make or let others know of such decisions.

   The Health Care Power of Attorney must:

   - State the name of the person you want to make health care decisions for you
   - State that this person may only make health care decisions for you when you cannot, if that is what you want
   - Be dated and signed by you

Your Health Care Power of Attorney may also:

- Include details about health care you want or do not want. This could include withholding procedures if you are in a "terminal condition." A "terminal condition" is when a patient cannot be cured and will die without life-sustaining procedures. (This must be stated in writing by two doctors.) A "terminal condition" is also if a patient is in a permanent vegetative state or an irreversible coma.
- Name a second person to make these decisions if the first person is not able to do so
- Include signatures of witnesses who are not related to you

2. **A Mental Health Care Power of Attorney** — is a document you could use if you want to appoint a person to make future mental health care decisions for you if you become unable to make decisions for yourself. The decision about whether you are unable to make decisions for yourself can only be made by a specialist who would evaluate whether you can give informed consent. If you fill out a form:
   - Be sure you understand the importance of the document
   - Talk to your loved ones and doctor if you have questions about the type of mental health care you do or do not want
   - Do not sign until you have a witness or notary public to watch you sign it
3. **A Living Will** — is a written statement (legal document) about health care you want or do not want if you cannot make these decisions. A Living Will can say if you want to be fed with a tube if you are not conscious and unlikely to recover or if you cannot eat or drink. A Living Will may direct doctors to withhold or continue procedures if you are in a "terminal condition." You can tell doctors whether to use other life-sustaining procedures. Your doctors will use your Living Will only if you are not able to state your health care decisions.

   General advice on making a valid Living Will:
   - Obtain a Living Will from your attorney or from dependable professional sources, such as stationery stores or trustworthy online sites
   - Sign and date your Living Will in front of two witnesses who must also sign it
   - Neither witness may be directly involved in your care

   In addition, one of the witnesses must not:
   - Be related to you by blood or marriage
   - Have a right to any of your estate
   - Have a claim against the estate
   - Directly pay for your medical care

4. **A pre-hospital medical care directive** — is a written directive (legal document) refusing certain lifesaving care given outside a hospital or in an emergency room. This must be completed as required by law. This form will list these types of treatments you may refuse:
   - Chest compression (to restart your heart)
   - Defibrillation (electronically correcting the heart beat)
   - Assisted ventilation (breathing by machine)
   - Intubation (supplying air through a tube)
   - Advanced life support drugs

   If you want a Pre-Hospital Directive, talk to your PCP.

   Also, a Pre-Hospital Directive must:
   - Be signed or marked by you and dated
   - Be signed by a licensed health care provider and a witness

Q: Who has the right to make health care decisions?

A: You do, if you are able to make and let providers know of your decisions. You decide what health care, if any, you will not accept.

Q: What if I become unable to make or let providers know of my health care decisions?

A: You can still have some control if you have an Advance Directive. Your provider must put in your record if you have an Advance Directive. If you have not named someone in your Advance Directive, your PCP must seek a person authorized by law to make such decisions.

Q: Must my Advance Directive be followed?

A: Yes. Health care providers and the person you name in your directive must follow a valid Advance Directive.

Q: Must a lawyer write my Advance Directive?

A: Not necessarily; however, it is good practice and advisable to have a lawyer or legal advisor review any legal document. Local and national groups can give you facts and forms. Be sure any Advance Directive you use is valid under Arizona law.

Q: Who should have a copy of my Advance Directive?

A: Give a copy to your PCP. Give it to any health care center on admission. If you have a Health Care Power of Attorney, give a copy to the person you have named on it. Keep extra copies for yourself and your Case Manager. Also, keep your copy in a place that is safe and easy to get to.

Q: Can I be required to make an Advance Directive?

A: No. Whether you make one is up to you. A provider cannot refuse care based on whether you have one.

Q: Can I change or cancel my Advance Directive?

A: Yes, but it is important you follow the same steps as outlined above. If you change or cancel it, let your Case Manager and PCP know.

Q: What if I already have an Advance Directive?

A: You may want to review it or have it reviewed by an attorney or legal advisor. If it was done in another state, make sure it is valid in Arizona. If you did it before September 1992, the law has changed. New choices are available so you may consider making a new one.

Q: Does Arizona law limit what can be done under an Advance Directive?

A: The Arizona law does not allow acts or omission (not acting) leading to the injury or death of physically or mentally impaired adults. It is important to have a proper Advance Directive that states your wishes on the treatment(s) you do/do not want.

Q: Who can legally make health care decisions for me if I cannot make them and I have no Advance Directive?

A: A court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down this list to find someone:

- Your husband or wife, unless you are legally separated
- Your adult child. If you have more than one adult child, a majority of them.
- Your mother or father
- Your domestic partner, unless someone else has financial responsibility for you
- Your brother or sister
- A close friend of yours. (Someone who shows special concern for you and knows your health care views.)

If your provider cannot find a person to make health care decisions for you, your PCP can decide. Your PCP can do this with an ethics committee or the approval of another physician.

You can keep anyone from making decisions for you by saying so in writing. For example, the person you name in your Advance Directive will not have the right to refuse the use of tubes to give you food or fluids — if this is what you want — unless:

- You have appointed that person to make decisions for you in a Health Care Power of Attorney
- A court has appointed that person as your guardian to make health care decisions for you
- You have stated in an Advance Directive that you do not want this treatment

If you have questions about Advance Directives, ask your Case Manager.

*** UnitedHealthcare Community Plan is providing general Advance Directive information; Always consult your lawyer or legal advisor before signing any legal document.**

Fraud, waste, and abuse

Fraud

UnitedHealthcare Community Plan provides services to people who are in need and qualify for services. It is important to make sure that our members and providers follow the rules for getting and billing for covered services. If the rules aren't followed, a member or provider might be committing fraud. Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2. Report anything you see that doesn't look right. This includes:

- Using someone else's ID card or allowing someone to use yours
- Giving a wrong address in order to qualify for AHCCCS
- A doctor or facility billing you for covered services
- A doctor giving you services you don't need
- A provider offering inappropriate services

Waste

Over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program. 42 CFR 455.2.

Abuse of member

Abuse of a member is defined by Arizona law (A.R.S. 46-451 and 13-3623). It means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

Reporting fraud, waste, and abuse

Fraud, waste and abuse are serious offenses. There can be penalties under the law. You can report fraud, waste or abuse by calling Member Services. You can call AHCCCS toll free outside of Arizona only: 888-ITS-NOT-OK or 1-888-487-6686, or in Arizona call 602-417-4193 or email **AHCCCSFraud@azahcccs.gov**. Or, go to their website, **azahcccs.gov**. You can report member, provider, or contractor suspected fraud or abuse of the program with an AHCCCS online form: **www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx**. You do not have to give your name. You will not get in trouble for reporting fraud, waste or abuse.

A provider may commit fraud, waste or abuse. Examples are:

- Giving you care you do not need
- Billing for services you did not get
- Keeping you in a hospital longer than you need
- Inflicting mental or physical harm
- Misuse of your trust fund
- Failure to carry out your plan of care

If you think fraud, waste or abuse is going on with providers, staff, or other members, call Member Services at **1-800-293-3740**, TTY **711**. We will not use your name in your report. You will not get in trouble for reporting this. We will look into the matter for you. You can also call AHCCCS at **1-888-487-6686** or **602-417-4193** or go to their website at **www.azahcccs.gov**. You do not have to give your name.

Member and family member support information and community resources and the Office of Individual and Family Affairs (OIFA)

Advocates/Liaisons/Coordinators — UnitedHealthcare Community Plan supports our members by having member liaisons and Office of Individual and Family Affairs to support members' needs where unique community resources are available. These liaisons can be reached by emailing **advocate.oifa@uhc.com** or calling Member Services at **1-800-293-3740**. Examples of these supports are listed below:

Adult Member Liaison — A member liaison with adult behavioral health experience works with adult members with special health care needs, their families, member liaisons and others within the community. The adult behavioral member liaison will assist members navigate between their physical, behavioral health and social needs. They will make certain that request, complaints, and concerns are addressed and followed up to completion for the member.

Child and Family Member Liaison — A member liaison with child behavioral health experience working with children with special health care needs, their families, member liaisons and other within the community. The child and family behavioral member liaison will assist members/parent(s)/guardian(s) to navigate between their child's physical, behavioral health and social needs. They will make certain that request, complaints, and concerns are addressed and followed up to completion for the member/parent(s)/guardian(s).

Court Coordinator — A single point of contact for information specific to the court's disposition for eligible members (e.g. Drug Court, Mental Health Court, Criminal Proceedings), coordination of court ordered evaluation and treatment, and who assist to assure court related follow-up.

CRS Liaison — Your single point of contact for members with a CRS designation. This person works with the members assigned Multi-Specialty Interdisciplinary Clinic (MSIC) to help members/parent(s)/guardian(s) navigate between their child's physical, specialty care, behavioral health and social needs. They will make certain that requests, complaints, and concerns are addressed and followed up to completion for the member/parent(s)/guardian(s). For more information email **CRS_SpecialNeeds@UHC.com**.

Employment/Vocational Administrator — The employment/vocational administrator is dedicated to employment and rehabilitation related activities. The administrator develops vocational services to assist members in achieving their rehabilitation/employment goals and ensures that behavioral health providers are engaging in employment discussions with members. The administrator is responsible for managing and overseeing employment support programs for providers with the goal of increasing employment outcomes for members.

Justice System Liaison — Your single point of contact for communication with the justice system; This person works with the Arizona Department of Corrections (ADOC), County Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Juvenile Corrections (ADJC), Arizona Office of the Courts (AOC) and Probation Departments.

Tribal Coordinator — Coordinates care and service for American Indian members with tribal nations and tribal providers, promoting services and programs to improve the health of American Indian members. The Tribal Coordinator assist to assure American Indian members request, complaints, and concerns are addressed and followed up to completion.

Veterans Liaison — The Veterans Liaison is experienced in working with Veterans and family members of veterans, advocates and providers. The Liaison provides education and support to our veterans to help them through the health system to ensure their needs are met. Additionally, they provide assistance to members needs such as employment and housing resources. Their goal is to provide one-on-one support to our Veteran members. For more information email the Veteran Liaison at **milvet_advocate@uhc.com**.

Community resources

AHCCCS Office of Individual and Family Affairs

The Office of Individual and Family Affairs (OIFA) promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges.
https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA.html

Peer-Run and Family-Run organizations

Peer-run organizations are service providers owned, operated and administrated by persons with lived experiences of mental health and/or substance use disorders. These organizations are based in the community and provide support services.

Here are some of the things you can find at a peer-run organization:

- 1-on-1 peer support
- Daily support groups
- Social outings
- Meals
- Employment programs
- Learning opportunities
- Health and exercise programs
- Creative arts
- Resources
- Advocacy
- Volunteer opportunities
- Youth and young-adult programs
- Meeting new people
- Personal development, and empowerment
- Extended hours and/or weekends

https://www.azahcccs.gov/AHCCCS/Downloads/PeerRunOrganizationsFlyer.pdf

ARIZONA@WORK

This statewide job center offers a wide array of workforce services at no cost to connect Arizona job seekers to gainful employment. Through ARIZONA@WORK, you can connect with local employers who have immediate job openings on Arizona's largest employment database, the Arizona Job Connection website.

ARIZONA@WORK can connect you to their partners for expert advice and guidance on everything from childcare, basic needs, Vocational Rehabilitation for job seekers with disabilities, and educational opportunities.

For more information and to locate the nearest ARIZONA@WORK office, visit **https://arizonaatwork.com/**.

2-1-1 Arizona

This website helps you find resources for child care, jobs, food, health care, and insurance. It shows bulletins and alerts for disaster or emergency. It partners with government, tribal, non-profit and community groups to help you find resources.
Phone: **2-1-1** within Arizona or **1-800-367-8939** TDD
https://211arizona.org/

Arizona Alzheimer's Association

http://www.alz.org/dsw/
or by phone: **1-800-272-3900** for the Alzheimer's Association 24-hour helpline

Arizona Caregiver Coalition

Their mission is to improve the quality of life for family caregivers across Arizona through Collaborative Partnerships, Advocacy, Resources, and Respite Support.

https://azcaregiver.org
Caregiver Toll-Free Resource Line: **1-888-737-7494**
or by email: **info@azcaregiver.org**

Arizona Child Care Resource & Referral

Arizona Child Care Resource & Referral helps families find the best information on locating quality child care, early childhood resources in their community. They support families in making childcare choices for their children to prepare them for school readiness and a bright future. For more information go to **www.AZCCRR.com** or call 1-800-308-9000

Arizona Coalition for Military Families

The Arizona Coalition for Military Families is a nationally recognized partnership focused on building Arizona's statewide capacity to care for, serve and support service members, veterans, their families and communities.

www.Arizonacoalition.org
Locally: 602-753-8802

Arizona Coalition Against Sexual and Domestic Violence

Their mission is to lead, to advocate, to educate, to collaborate, to prevent and end sexual and domestic violence in Arizona.

http://www.acesdv.org/
Locally: **602-279-2900**
Toll-Free: **1-800-782-6400**
TTY/TDD: **602-279-7270**

Arizona Department of Health Services (ADHS) Breastfeeding Program 24/7 Hotline

Get answers to your breastfeeding questions 24 hours a day by calling the 24-Hour Breastfeeding Hotline at **1-800-833-4642** or by visiting **www.gobreastmilk.org**.

Arizona Governor's Council on Spinal and Head Injuries

www.headspineaz.org
or by phone: **1-602-774-9147**

AzEIP

The Arizona Early Intervention Program (AzEIP) is a statewide system of supports and services for families and children birth to age 3, with disabilities or developmental delays. For more information about AzEIP, call 602-532-9960, call toll-free at 1-888-439-5609, or visit the website at **des.az.gov/services/disabilities/developmental-infant**. If AzEIP services are provided by UnitedHealthcare Community Plan, call **1-800-293-3740**, or visit the website **UHCCommunityPlan.com**.

AZ Links

AZ Links is Arizona's Aging and Disability Resource Center (ADRC), created to help Arizona Seniors, People with Disabilities, Caregivers and their Family Members locate resources and services that meet their needs.
Visit **www.azlinks.gov**.

AZ Suicide Prevention Coalition

To change those conditions that result in suicidal acts in Arizona through awareness, intervention, and action.
http://www.azspc.org

Count the Kicks

A no-cost app based program that allows pregnant members to count and track fetal movement in their 3rd trimester.

https://countthekicks.org

Cyber-Seniors

Cyber-Seniors provides no-cost technology support and training for senior citizens.

1-844-217-3057
https://cyberseniors.org

Diabetes care

American Diabetes Association:
http://www.diabetes.org

You can also call the American Diabetes Association at **1-800-DIABETES** (1-800-342-2383). Hours are 8:30 a.m.–8:00 p.m. Eastern Standard Time, Monday–Friday.
Or write:
American Diabetes Association
ATTN: Center for Information
2451 Crystal Drive, Suite 900
Arlington, VA 22202

Dump the Drugs AZ

https://azdhs.gov/gis/dump-the-drugs-az/
602-542-1025

Fussy Baby/Birth to Five Helpline

Provides support for parents who are concerned about their baby's temperament or behavior.
Helpline: 1-877-705-5437, 8:00 a.m.–8:00 p.m., Monday–Friday
www.raisingarizonakids.com/2019/01/birth-to-five-helpline-soothe-fussy-babies

Head Start/Early Head Start

Head Start/Early Head Start is a program that provides health, educational, nutritional, social, and other services to low-income children and families. Head Start/Early Head Start programs create learning environments that support a child's growth in language, literacy, mathematics, science, social and emotional functioning, creative arts, and physical skills. To learn more about the Head Start/Early Head Start program or to find a program in your area, call 1-866-763-6481 or visit the Head Start/Early Head Start websites at **http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartoffices** or **https://www.azheadstart.org/**.

Health-e-Arizona Plus

Get information about AHCCCS coverage and apply online at **www.healthearizonaplus.gov** or call **1-855-432-7587**, 7:00 a.m.–6:00 p.m., Monday–Friday. Allows AHCCCS members to view information about their health care and plan enrollment for:

- AHCCCS
- Part D, which is the Medicare prescription drug benefit
- KidsCare
- Behavioral Health
- Medicare
- Other Medical Insurance

AHCCCS members may also view two years of enrollment information. Members can link to their health plan websites. Members can view their health plan enrollment date. They can link to the annual enrollment change website. Members can verify if AHCCCS has their correct address.

Help to stop smoking

Would you like to make a plan to quit smoking? Visit **myuhc.com/CommunityPlan** for more information on your tobacco cessation benefits. You can also get support and information from Quit for Life® at **quitnow.net** or call **Quit For Life®**. Get free help quitting smoking (toll-free). **1-866-784-8454**, TTY **711**

There are community support groups, cessation treatment, care and services available to members available at **www.azdhs.gov/tobaccofreeaz/**.

Or contact ASHLine Arizona Smokers' Helpline: **1-800-55-66-222**. For Prescription to Quit, ASHLine will call you back within three days. If you're ready to QUIT NOW do not wait, call now **1-800-55-66-222**. **www.ashline.org**

Home Visiting Programs

Home visiting programs are available for pregnant women and families with children birth to age 3. There is no cost and a trained home visitor comes to the home to help families with education on topics such as: parenting, breastfeeding, employment and child care solutions, child abuse/child neglect prevention, child development, health and wellness, and school readiness.

If you live in Maricopa County and would like more information on Home Visiting programs, contact Parents Partners Plus at **602-633-0732** or fill out a referral form here: **https://www.parentpartnersplus.com**. Outside Maricopa County, go to **https://strongfamiliesaz.com/programs/** to find information on Home Visiting programs available in your area.

Mentally Ill Kids in Distress (MIKID)

MIKID improves the behavioral health and wellness of children and youth through a family-centered approach.
http://www.mikid.org

National Alliance on Mental Illness (NAMI)

NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

http://www.namiarizona.org/
602-244-8166

National Suicide and Crisis Lifeline

https://988lifeline.org
Call or text: **988**

The National Suicide Prevention Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. The **988** Suicide and Crisis Lifeline offers call, text and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress. People can also dial **988** if they are worried about a loved one who may need crisis support.

Teen Lifeline:
https://teenlifeline.org/
602-248-8336 (TEEN)
800-248-8336 (TEEN)

Optum Community Centers

Lack of exercise and other physical activity may increase the risk of chronic conditions such as heart disease, depression and diabetes. Free videos to help older adults stay healthy, active and resilient.
https://www.youtube.com/playlist?list=PLsqiKKQGf-B91F0_ERCPKeijAV7og_fq7

Opioid assistance and referral

Local medical experts offer patients, providers, and family members opioid information, resources and referral 24/7. Translation services available.
1-888-688-4222
www.bannerhealth.com/services/poison-drug-information/opioid-assistance

AHCCCS Opioid Service Locator:
https://opioidservicelocator.azahcccs.gov/

Poison Control

Poison Control is available 24 hours a day to provide no cost, expert and confidential guidance in a poison emergency. If the individual collapses, has a seizure, has trouble breathing, or can't be awakened: **Call 911 immediately.**
1-800-222-1222
www.poison.org

Postpartum Support International (AZ Chapter Resource List)

Warmline: **1-888-434-6667**
www.postpartum.net

Power Me A2Z

Free vitamins for Arizona women ages 18–45 from the Arizona Department of Health Services.
www.powermea2z.org

Raising Special Kids – Arizona's family-to-family health information center

Raising Special Kids is a non-profit organization of families helping families of children with disabilities and special health needs in Arizona. They provide information, training and materials to help families understand and navigate systems of care. Parents are supported in their leadership development as they learn to advocate for their children. Raising Special Kids promotes opportunities for improving communication between parents, youth with disabilities, educators and health professionals. All programs and services are provided to families at no cost.

Raising Special Kids
5025 East Washington Street, Suite 204
Phoenix, AZ 85034

1-800-237-3007 Toll-Free
602-242-4366
www.raisingspecialkids.org

Sliding fee clinics

If a member loses AHCCCS eligibility there are clinics around the state that offer low to no cost services. Contact the Arizona Department of Health for more information.
602-542-1025
https://azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php

Vaccines for Children (VFC)

The Vaccines for Children (VFC) Program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to afford vaccines. Children that are 18 years and under and meet at least one of the following criteria are eligible to receive vaccines from the VFC program:

- AHCCCS enrolled — Children who are eligible for the state Medicaid program
- Uninsured — Children not covered by any health insurance plan
- American Indian/Alaska Native (AI/AN) — This population is defined by the Indian Health Care Improvement Act (25 U.S.C. 1603). AI/AN children are VFC eligible under any circumstance
- Under-insured* — Children who have private insurance that does not cover some or all Advisory Committee on Immunization Practices (ACIP) recommended vaccines

* Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), county health departments and approved deputized providers are the only providers that are allowed to serve the VFC eligibility category of underinsured.

https://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#program-overview

Vocational Rehabilitation (VR)

VR is a program within the Arizona Department of Economic Security (ADES) designed to assist eligible individuals who have disabilities prepare for, get, and keep a job.

You may be eligible for VR services if you meet the following requirements:

- You have a physical or mental disability
- Your physical or mental disability results in a significant barrier to employment
- You require VR services in order to prepare for, get, keep, or regain employment
- You can benefit from VR services in terms of achieving an employment outcome

Once you apply for the VR program and are determined eligible, you will work with the VR counselor to develop a plan for employment. Plan development includes identifying a competitive employment goal and will address any disability-related barriers to employment. Ask your Support Coordinator about a referral to VR.

For more information and to locate the nearest VR office to you, visit **https://des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation-vr**.

WIC

The Arizona Women, Infants, and Children Program (WIC) provides Arizona residents with nourishing supplemental foods, nutrition education, and referrals. People who use WIC are women who either are pregnant, breastfeeding, or have just had a baby; as well as infants and children up to five years of age who have nutritional needs and meet income guidelines. Call the WIC hotline at 1-800-252-5942 or visit **www.azwic.gov** for more information.

Area Agency on Aging

The Area Agencies on Aging (AAA) were established through the Older Americans Act amendments of 1972 in order to provide a local structure for addressing the needs and concerns of older persons. The goal of the Area Agency on Aging is to enable older people to maintain maximum independence and dignity within their own homes and communities as long as possible by developing a system of coordinated, comprehensive services to meet their needs. The AAA also provides State Health Insurance Assistance Programs (SHIP). They can educate about Medicare and the different Medicare Plan options. They also offer Family Caregiver Support Programs to meet Caregiver range of needs. The AAAs are listed below by county.

Maricopa County
http://www.aaaphx.org

Area Agency on Aging, Region One
1366 East Thomas Road, Suite 108
Phoenix, AZ 85014
Phone: **602-264-2255**
Toll-Free: **1-888-783-7500**
Fax: **602-230-9132**
24 hour Senior Help Line for urgent matters: **602-264-4357**
Toll-Free: **1-888-783-7500**
For hard of hearing — Text **520-775-1899**

Coconino, Yavapai, Apache, and Navajo Counties
http://nacog.org

Northern Arizona Council of Governments (NACOG)

AAA Office:
323 N. San Francisco Street, Suite 200
Flagstaff, AZ 86001
Phone: **928-774-1895**
Toll-Free: **877-521-3500**
Fax: **928-774-3850**

Central Office:
119 East Aspen Avenue
Flagstaff, AZ 86001
Phone: **928-774-1895**
Toll-Free: **1-877-521-3500**
Fax: **928-773-1135**

LaPaz, Mohave, and Yuma Counties
http://www.wacog.com/

Western Arizona Council of Governments (WACOG)
Central Intake Phone: **1-800-782-1886**

Mohave County
208 North Fourth Street
Kingman, AZ 86401
Phone: **928-753-6247**

Gila and Pinal Counties
Area Agency on Aging, Region Five
Pinal-Gila Council for Senior Citizens
8969 West McCartney Road
Casa Grande, AZ 85194-7432
Phone: **520-836-2758**
Toll-Free: **1-800-293-9393**

Pima County
http://www.pcoa.org/

Pima Council on Aging
8467 East Broadway Boulevard
Tucson, AZ 85710
Phone: **520-790-7262**
Fax: **520-790-7577**

Support and advocacy

Contact your Case Manager if you need assistance getting services.

Centers for independent living

Maricopa County:
Ability 360
ABIL-5025 East Washington Street, Suite 200
Phoenix, AZ 85034
Phone: **602-256-2245**
Toll-Free: **1-800 280-2245**

Northern Arizona — all counties:
New Horizons Disability Empowerment Center
9400 East Valley Road
Prescott Valley, AZ 86314
Voice/TTY: **928-772-1266**
Website: **https://www.nhdec.org/**

Coconino, Navajo, and Apache Counties:
ASSIST! to Independence
P.O. Box 4133
Tuba City, AZ 86045
Phone: **1-928-283-6261**
Toll-Free: **1-888-848-1449**
Website: **http://www.assistti.org/**

Arizona Center for Disability Law
5025 East Washington Street, Suite 202
Phoenix, AZ 85034
Phone: **602-274-6287** (voice or TTY)
1-800-927-2260 (toll-free)
Fax: **602-274-6779**
Website: **www.azdisabilitylaw.org**

Behavioral Health advocacy

National Lifeline for Suicide Prevention and Support

https://suicidepreventionlifeline.org/
Contact National Lifeline for Suicide Prevention and Support weekdays by calling **1-480-994-4407** for community information and resources outside Maricopa County, **1-800-273-8255** for suicide prevention, and call the Behavioral Health crisis line at **602-222-9444**; TTY/TDD **602-274-3360**; or toll-free at **800-631-1314**; TTY/TDD **800-327-9254**.

Mailing address is:

National Lifeline for Suicide Prevention and Support
5110 North 40th Street, Suite 201
Phoenix, AZ 85018

National Alliance on Mental Illness (NAMI)

NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

http://www.namiarizona.org/
602-244-8166

Arizona Center for Disability Law (ACDL)

ACDL is a not-for-profit which is dedicated to protecting the rights of individuals with physical, mental, psychiatric, sensory and cognitive disabilities.

https://www.azdisabilitylaw.org/
602-274-6287 or
1-800-927-2260

Special Assistance for members determined to have SMI

The Office of Human Rights (OHR) provides advocacy to individuals living with a SMI to help them understand, protect and exercise their rights, facilitate self-advocacy through education, and obtain access to behavioral health services in the public behavioral health system in Arizona. OHR provides Special Assistance for SMI designated members who meet criteria.

What is Special Assistance?

Special Assistance: A support intended to enhance SMI designated members ability to participate in the selection of covered services and protect his/her rights as defined in the Arizona Administrative Code. (A.A.C. R9-21-100 et. seq.).

Special Assistance is a clinical determination made by a qualified clinician. The Special Assistance designation is reserved for enrolled SMI designated members who are unable to articulate treatment preferences and/or participate effectively in the development of the ISP, ITDP, grievance and/or appeal processes due to a cognitive or intellectual impairment, a medical condition (including severe psychiatric symptoms) or a language barrier (that cannot be resolved through an interpreter). SMI designated members that have a court appointed guardian automatically meet criteria for Special Assistance. OHR provides at no cost, an OHR advocate (if there is not a natural support designated representative or court appointed guardian):

- Preparation for and assistance at member Individual Service Plan (ISP) meetings, and when inpatient, Inpatient Treatment & Discharge Plan (ITDP) meetings
- Follow-up on implementation of services — which can include informal intervention, or use of appeal and/or grievance processes
- On-going involvement with the member and clinical team to support informed choice, protection of rights and development of self-advocacy, to the greatest extent possible

Special Assistance qualifications:

- The person has an SMI designation
- The person has a court appointed guardian, or
- The person is unable to do any of the following:
  - Communicate preferences for services,
  - Participate effectively in service planning (ISP) or inpatient treatment and discharge (ITDP) planning, or
  - Participate effectively in the appeal, grievance, and/or investigation processes.

It is the responsibility of every member of the clinical team to assess members that have an SMI determination for Special Assistance criteria during any Individual Service Planning (ISP), Inpatient Treatment & Discharge Planning (ITDP), grievance or appeal process and when conditions exist that may result in an SMI appeal or grievance process. Once a clinical determination is made that a member meets criteria the team will send notification to the assigned Health Plan and the OHR.

Who can assess for Special Assistance:

- Qualified clinician
- Case Manager
- Clinical team
- Regional Behavioral Health Agreement (RBHA) and Tribal Regional Behavioral Health Authority (TRBHA)
- Program director of a subcontracted provider
- AHCCCS deputy director
- Administrative hearing officer

Required assessments and notifications:

- All members with a SMI designation must be assessed for Special Assistance
- When an individual is identified as meeting criteria for Special Assistance, notification to the OHR is required
- Notifications are submitted via the AHCCCS Quality Management/OHR Special Assistance Portal and are required within five business days of an individual meeting Special Assistance criteria

When an OHR Advocate is assigned

The OHR determines who will meet the needs upon receiving a Special Assistant notification and will assign an OHR Advocate to fulfill the advocacy role on the members' behalf, if no one is identified. The OHR will provide the following to members assigned:

- Direct advocacy
- Education and resources
- Ongoing communication and involvement
- Preparation and participation
- Follow-up on implementation of services

OHR operates a single statewide phone line during business hours to provide technical assistance to anyone living with a Serious Mental Illness. Technical assistance could include:

- Providing education and resources for behavioral health services in Arizona,
- Helping a person understand their rights as an individual living with a Serious Mental Illness,
- Helping an individual to understand their treatment options, and
- Educating about the grievance and/or appeal process.

To reach OHR please call 1-800-421-2124 or visit **www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/ohr.html**.

ALTCS advocates and advocacy systems

General member rights under the Home and Community Based Services (HCBS)

The HCBS Rules are purposed to provide protections to members and assure full access to the benefits of community living. The HCBS Rules focus attention on ensuring that members are actively engaged and participating in their communities to the same degree as any other Arizonan through employment, education, volunteer and social and recreational activities.

The HCBS Rules stipulate that HCBS residential and non-residential settings must have the following qualities:

1. The setting is integrated in and supports full access to the greater community, including opportunities to:
   a. Seek employment and work in competitive integrated settings,
   b. Engage in community life,
   c. Control personal resources, and
   d. Receive services in the community to the same degree of access as individuals not receiving Medicaid HCB services.
2. The setting is selected by the individual from among setting options including
   a. Non-disability specific settings, and
   b. An option for a private unit in a residential setting.
3. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
4. Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint.
5. Optimizes, but does not regiment, individual initiative, autonomy and independence in making

life choices including but not limited to, daily activities, physical environment, and with whom to interact.

6. Facilitates individual choice regarding services and supports and who provides them.
7. In a provider-owned or controlled home and community-based residential settings, the following additional requirements must be met:
   a. The individual has a lease or other legally enforceable agreement providing similar protections,
   b. The individual has privacy in their sleeping or living unit including:
      - Lockable doors by the individual with only appropriate staff having keys to the doors,
      - Individual sharing units have a choice of roommates in that setting,
      - Freedom to furnish or decorate the unit within the lease or agreement,
   c. The individual has freedom and support to control his/her own schedules and activities including access to food at any time,
   d. The individual can have visitors at any time, and
   e. The setting is physically accessible.

Long Term Care Ombudsman

This program grew out of efforts by both federal and state governments to respond to widely reported concerns that our most frail and vulnerable citizens (those living in long term care facilities) were subject to abuse, neglect and substandard care. These residents also lacked the ability to exercise their rights or voice complaints about their circumstances. The primary purpose of the Long Term Care Ombudsman Program is to identify, investigate and resolve complaints made by or on behalf of residents of long term care facilities.

- Educating residents, families, facility staff and the community about long term care issues and services
- Promoting and advocating for residents' rights
- Assisting residents in obtaining needed services
- Working with and supporting family and resident councils
- Empowering residents and families to advocate for themselves

The Ombudsman Program will make every reasonable effort to assist, advocate and intervene on behalf of the resident. When investigating complaints, the program will respect the resident and the complainant's confidentiality and will focus complaint resolution on the resident's wishes.

The Ombudsman Program accepts complaints from any source. If you have a complaint, concern or would like more information, the Ombudsman Program is available to assist you. To contact your local Long Term Care Ombudsman, contact your local Area Agency on Aging.

Centers for independent living

Maricopa County:
Ability 360
ABIL-5025 East Washington Street
Phoenix, AZ 85034
Phone: **602-256-2245**

Northern Arizona — all counties:
New Horizons Disability Empowerment Center 9400 East Valley Road
Prescott Valley, AZ 86314
Voice/TTY: **928-772-1266**

Coconino, Navajo, and Apache Counties:
ASSIST! to Independence
P.O. Box 4133
Tuba City, AZ 86045
Phone: **1-928-283-6261**

Arizona Center for Disability Law
5025 East Washington Street, Suite 202
Phoenix, AZ 85034
Phone: **602-274-6287** (voice or TTY)
1-800-927-2260 (toll-free)
Fax: **602-274-6779**
Website: www.azdisabilitylaw.org

Legal aid

Apache County
White Mountain Legal Aid
a division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
Phone: **928-537-8383 / 1-800-658-7958**

Coconino County
DNA People's Legal Services
2323 East Greenlaw Lane, Suite 1
Flagstaff, AZ 86004
Phone: **928-774-0653 / 1-800-789-5781**

Gila County
White Mountain Legal Aid
a division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
Phone: **928-537-8383 / 1-800-658-7958**

Maricopa County
Community Legal Services
305 South 2nd Avenue
Phoenix, AZ 85003
Phone: **602-258-3434 / 1-800-852-9075**

Mohave County
Community Legal Services
2701 East Andy Devine, Suite 400
Kingman, AZ 86401
Phone: **928-681-1177 / 1-800-255-9031**

Navajo County
White Mountain Legal Aid
a division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
Phone: **928-537-8383 / 1-800-658-7958**

Navajo Nation
DNA – Chinle Agency Office
P.O. Box 767
Chinle, AZ 86503
Phone: **928-674-5242 / 1-800-789-7598**

DNA – Fort Defiance Agency Office
P.O. Box 306
Window Rock, AZ 86515
Phone: **928-871-4151 / 1-800-789-7287**

DNA – Hopi Legal Services
P.O. Box 558
Keams Canyon, AZ 86034
Phone: **928-738-2251 / 1-800-789-9586**

DNA – Tuba City Agency Office
P.O. Box 3539
Tuba City, AZ 86045
Phone: **928-283-5265**

Native American Disability Law Center
Farmington Office
905 W. Apache Street
Farmington, NM 87401
Phone: **505-566-5880 / 1-800-862-7271**

Pinal County
Southern Arizona Legal Aid
1729 North Trekell Road, Suite 101
Casa Grande, AZ 85122
Phone: **520-316-8076 / 1-877-718-8086**

Tohono O'odham Legal Services-Sells Profile
P.O. Box 246,
Main & Education Streets
Sells, AZ 85634
Phone: **928-383-2420**

White Mountain Apache Tribe
White Mountain Apache Legal Aid
a division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
Phone: **928-537-8383 / 1-800-658-7958**

Yavapai County
Community Legal Services
148 N Summit Ave
Prescott, AZ 86301
Phone: **928-445-9240 / 1-800-233-5114**

Statewide
Arizona Center for Disability Law
5025 East Washington Street, Suite 202
Phoenix, AZ 85034
Phone: **602-274-6287 / 1-800-927-2260**

General legal information about your rights and website for each legal aid office:

www.azlawhelp.org

AZ disability benefits 101

There are a number of myths related to work and benefits. There are plenty of people living with disabilities who are on benefits and work and are better off. Having a disability does not mean you cannot work. Talk with your Support Coordinator or employment specialist for more information on the following resources:

Arizona Disability Benefits 101 (DB101) — This no-cost, user-friendly online tool helps people work through the myths and confusion of Social Security benefits, healthcare, and employment. DB101 supports people to make informed decisions when thinking about getting a job by learning how job income and benefits go together. Visit **http://az.db101.org/** to access this valuable tool.

ABILITY360 — Within ABILITY360 is a program called Benefits 2 Work Arizona's Work Incentives Planning & Assistance (B2W WIPA) that can help you understand how job income will affect your cash, medical, and other benefits through a benefits analysis. To reach an intake specialist, call the B2W WIPA program at 602-443-0720 or 1-866-304-WORK (9675), or email at **b2w@ability360.org**, and see if you might qualify for this service at no cost.

Arizona Center for Disability Law (ACDL)

ACDL is a not-for-profit which is dedicated to protecting the rights of individuals with physical, mental, psychiatric, sensory and cognitive disabilities. **https://www.azdisabilitylaw.org/**

Low-income housing

For information on low-income housing and shelter:
https://211arizona.org/

Income-based housing

- Subsidized apartment search:
  https://resources.hud.gov/ Subsidized apartment search
- Public Housing Authorities:
  https://www.hud.gov/program_offices/public_indian_housing/pha/contacts
- Housing Choice Vouchers (Section 8):
  https://www.hud.gov/topics/housing_choice_voucher_program_section_8
- Section 202 Supportive Housing for the Elderly:
  https://www.hud.gov/program_offices/housing/mfh/grants/section202ptl
- Section 811 Supportive Housing for Persons with Disabilities:
  https://www.hud.gov/program_offices/housing/mfh/grants/section811ptl

Eviction prevention resources

- Emergency Rental Assistance:
  https://www.consumerfinance.gov/coronavirus/mortgage-and-housing-assistance/renter-protections/find-help-with-rent-and-utilities/
- HUD Approved Housing Counseling Agencies:
  https://apps.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&webListAction=search&searchstate=AZ
- Department of Housing & Urban Development subsidized apartment search tool
  https://resources.hud.gov/

To receive additional information regarding these programs, contact your Case Manager.

Community dental resources in Arizona

Clinic/ Organization	County	Phone number	Address	Website
Adelante Healthcare	Maricopa	1-877-809-5092	306 E Monroe Buckeye, AZ 85326	http://www.adelantehealthcare.com
Adelante Healthcare	Maricopa	1-877-809-5092	1705 W Main St Mesa, AZ 85201	http://www.adelantehealthcare.com
Adelante Healthcare	Maricopa	1-877-809-5092	15351 W Bell Rd Surprise, AZ 85374	http://www.adelantehealthcare.com
Arizona School of Dentistry and Oral Health	Maricopa	480-248-8100	5855 E Still Circle Mesa, AZ 85206	https://www.atsu.edu/arizona-school-of-dentistry-and-oral-health/dental-clinics
Canyonlands Community Healthcare	Coconino	928-645-9675	827 Vista Ave Page, AZ 86040	https://canyonlandschc.org
Canyonlands Community Healthcare	Navajo	928-697-8154	Chilchinbeto Clinic Kayenta, AZ 86033	https://canyonlandschc.org
Canyonlands Community Healthcare (Beaver Dam)	Mohave	928-347-5971	3272 East Rio Virgin Rd Littlefield, AZ 86432	https://canyonlandschc.org
CARE Partnership	Maricopa	480-833-8987	466 S Bellview Mesa, AZ 85204 (call for appointment)	https://www.freeclinics.com
Clinica Adelante/ Tidwell Care	Maricopa	1-877-809-5092	306 E Monroe Ave Buckeye, AZ 85326	http://www.adelantehealthcare.com

Community dental resources in Arizona

Clinic/ Organization	County	Phone number	Address	Website
Coconino County Dept. of Health	Coconino	928-679-7355	2625 N. King Street Flagstaff, AZ 86004	http://www.coconino.az.gov/health
Donated Dental Services AZ Dental Foundation	480-344-5777 Often a waiting list.		3193 N. Drinkwater Blvd. Scottsdale, AZ 85251	http://www.azdentalfoundation.org
Valleywise Health (Avondale Family Health Center)	Maricopa	623-344-6800	950 E Van Buren St Avondale, AZ 85323	https://www.valleywisehealth.org
Valleywise Health (Chandler Family Health Center)	Maricopa	480-344-6109	811 South Hamilton Chandler, AZ 85225	https://www.valleywisehealth.org
Valleywise Health (Comprehensive Healthcare Center)	Maricopa	602-344-1015	2525 E Roosevelt St Phoenix, AZ 85008	https://www.valleywisehealth.org
Valleywise Health (ValleyWise Health Center)	Maricopa	602-655-2220	8088 W Whitney Peoria, AZ 85345	https://www.valleywisehealth.org

Community dental resources in Arizona

Clinic/ Organization	County	Phone number	Address	Website
Valleywise Health (McDowell Family Health Center – Specialty HIV)	Maricopa	602-344-8717	1101 N. Central Ave. Phoenix, AZ 85004	https://www.valleywisehealth.org
Valleywise Health (Mesa Family Health Center)	Maricopa	480-344-6209	59 S Hibbert Mesa, AZ 85210	https://www.valleywisehealth.org
Valleywise Health (South Central Family Health Center)	Maricopa	602-344-6600	33 W Tamarisk Phoenix, AZ 85041	https://www.valleywisehealth.org
Mesa Community College Dental Hygiene Clinic	Maricopa	480-248-8195	5855 E Still Circle Mesa, AZ 85206	https://www.mesacc.edu/programs/dental-hygiene
Mountain Park Health Center	Maricopa	602-243-7277	635 E Baseline Rd Phoenix, AZ 85042	https://mountainparkhealth.org/
Mountain Park Health Center	Maricopa	602-243-7277	6601 W Thomas Rd Phoenix, AZ 85033	https://mountainparkhealth.org/
Native American Community Health Center	Maricopa	602-279-5262	4041 N Central Ave Phoenix, AZ 85012	http://www.nativehealthphoenix.org/dental-services

Community dental resources in Arizona

Clinic/ Organization	County	Phone number	Address	Website
Neighborhood Christian Clinic	Maricopa	602-258-6008	1929 W Fillmore St Bldg C Phoenix, AZ 85009	http://thechristianclinic.org
North Country Healthcare	Coconino	928-522-9400	2920 N 4th St Flagstaff, AZ 86004	https://northcountryhealthcare.org
North Country Healthcare	Coconino	928-637-2305	112 Park Ave Ash Fork, AZ 86320	https://northcountryhealthcare.org
North Country Healthcare	Navajo	928-289-2000	620 W Lee St Winslow, AZ 86047	https://northcountryhealthcare.org
Northern AZ University Dental Hygiene Clinic	Coconino	928-523-3500	NAU 208 Pine Knoll Dr Bldg 66, Rm 215 Flagstaff, AZ 86011	http://nau.edu/CHHS/DDH/Clinic
Phoenix College Dental Hygiene Clinic	Maricopa	602-285-7323	1202 W Thomas Rd Bldg R Phoenix, AZ 85013	https://www.phoenixcollege.edu/community/community-services/dental-clinic
Phoenix Indian Medical Center	Maricopa	602-263-1592	4212 N 16th St Phoenix, AZ 85016	https://www.ihs.gov/phoenix/programs services/dental/
Rio Salado Dental Hygiene Clinic	Maricopa	480-377-4100	2250 W 14th St Tempe, AZ 85281	http://www.riosalado.edu/locations/dh/Pages/default.aspx

Community dental resources in Arizona

Clinic/ Organization	County	Phone number	Address	Website
Salt River Health Center	Maricopa	480-946-9066	10005 E Osborn Rd Scottsdale, AZ 85256	https://www.ihs.gov/phoenix/programs services/dental/
Smiles for Success	1-800-920-2293 Nationwide AZ dentists working through Smiles for Success restore women's smiles, free. Must meet eligibility requirements ... call for details.			https://smilesforsuccess.org
St. Vincent de Paul Dental Clinic	Maricopa	602-261-6868	420 W Watkins Rd Phoenix, AZ 85003	https://www.stvincentdepaul.net/
Sun Life Family Health Center	Pinal	520-381-0381	865 N Arizola Rd Casa Grande, AZ 85122	http://www.sunlifefamilyhealth.org
VA Medical Center Dental Clinic (100% disabled)	Maricopa	602-277-5551 ext: 6424	650 E Indian School Rd Phoenix, AZ 85012	http://www.phoenix.va.gov/services/Dental_Service.asp
VA Medical Center Dental Clinic (100% disabled)	Yavapai	928-445-4860 ext: 6177	500 Hwy 89 North Bldg 155, 1st Floor Prescott, AZ 86313	http://www.prescott.va.gov/services/Dental_Service.asp
Yavapai Community Health Center	Yavapai	928-639-8132	51 Brian Mickelsen Pkwy Cottonwood, AZ 86326	https://chcy.org/

Arizona Long Term Care offices

If you have questions about your share of cost or eligibility, call the ALTCS office in your area.

Casa Grande ALTCS Office
201 East Cottonwood Lane, Suite 2
Casa Grande, AZ 85122
Phone: **1-520-421-1500**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

Chinle ALTCS Office
Tseyi Shopping Center, Hwy. 191
P.O. Box 1942
Chinle, AZ 86503
Phone: **1-928-674-5439**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

Cottonwood ALTCS Office
Note: Cottonwood ALTCS staff are sharing space at the DES office.
1500 East Cherry Street, Suite I
Cottonwood, AZ 86326
Phone: **1-928-634-8101**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

Flagstaff ALTCS Office
2717 North Fourth Street, Suite 130
Flagstaff, AZ 86004
Phone: **1-928-527-4104**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

Globe/Miami ALTCS Office
Cobre Valle Plaza
2250 Highway 60, Suite H
Miami, AZ 85539-9700
Phone: **1-928-425-3165**
Toll-Free: **1-888-621-6880**
Fax: **1-928-425-7316**

Kingman ALTCS Office
519 East Beale Street, Suite 130
Kingman, AZ 86401
Phone: **1-928-753-2828**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

Phoenix ALTCS Office
801 East Jefferson Street, MD 3900
Phoenix, AZ 85034
Phone: **1-602-417-6600**
Fax: **1-602-253-6385**

Prescott ALTCS Office
Note: Prescott ALTCS staff are sharing space at the DES office.
3262 Bob Drive, Suite 11
Prescott Valley, AZ 86314
Phone: **1-928-778-3968**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

Tucson ALTCS Office
1010 North Finance Center Drive
Suite 201
Tucson, AZ 85710
Phone: **1-520-205-8600**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

Yuma ALTCS Office
3850 West 16th Street, Suite A
Yuma, AZ 85364
Phone: **1-928-782-0776**
Toll-Free: **1-888-621-6880**
Fax: **602-253-6385**

If your location is not listed, visit the AHCCCS website at **www.azahcccs.gov**.

Managed Care definitions

Appeal: To ask for review of a decision that denies or limits a service.

Copayment: Money a member is asked to pay for a covered health service, when the service is given.

Durable Medical Equipment: Equipment and supplies ordered by a health care provider for a medical reason for repeated use.

Emergency Medical Condition: An illness, injury, symptom or condition (including severe pain) that a reasonable person could expect that not getting medical attention right away would:

- Put the person's health in danger; or
- Put a pregnant woman's baby in danger; or
- Cause serious damage to bodily functions; or
- Cause serious damage to any body organ or body part.

Emergency Medical Transportation: See **Emergency Ambulance Services**.

Emergency Ambulance Services: Transportation by an ambulance for an emergency condition.

Emergency Room Care: Care you get in an emergency room.

Emergency Services: Services to treat an emergency condition.

Excluded Services: See **Excluded**.

Excluded: Services that AHCCCS does not cover. Examples are services that are:

- Above a limit,
- Experimental, or
- Not medically needed.

Grievance: A complaint that the member communicates to their health plan. It does not include a complaint for a health plan's decision to deny or limit a request for services.

Habilitation Services and Devices: See **Habilitation**.

Habilitation: Services that help a person get and keep skills and functioning for daily living.

Health Insurance: Coverage of costs for health care services.

Home Health Care: See **Home Health Services**.

Home Health Services: Nursing, home health aide, and therapy services; and medical supplies, equipment, and appliances a member receives at home based on a doctor's order.

Hospice Services: Comfort and support services for a member deemed by a Physician to be in the last stages (six months or less) of life.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Hospitalization: Being admitted to or staying in a hospital.

Medically Necessary: A service given by a doctor, or licensed health practitioner that helps with health problem, stops disease, disability, or extends life.

Network: Physicians, health care providers, suppliers and hospitals that contract with a health plan to give care to members.

Non-Participating Provider: See **Out of Network Provider**.

Out of Network Provider: A health care provider that has a provider agreement with AHCCCS but does not have a contract with your health plan. You may be responsible for the cost of care for out-of-network providers.

Participating Provider: See **In-Network Provider**.

In-Network Provider: A health care provider that has a contract with your health plan.

Physician Services: Health care services given by a licensed physician.

Plan: See **Service Plan**.

Service Plan: A written description of covered health services, and other supports which may include:

- Individual goals;
- Family support services;
- Care coordination; and
- Plans to help the member better their quality of life.

Preauthorization: See **Prior Authorization**.

Prior Authorization: Approval from a health plan that may be required before you get a service. This is not a promise that the health plan will cover the cost of the service.

Premium: The monthly amount that a member pays for health insurance. A member may have other costs for care including a deductible, copayments, and coinsurance.

Prescription Drug Coverage: Prescription drugs and medications paid for by your health plan.

Prescription Drugs: Medications ordered by a health care professional and given by a pharmacist.

Primary Care Physician: A doctor who is responsible for managing and treating the member's health.

Primary Care Provider (PCP): A person who is responsible for the management of the member's health care. A PCP may be a:

- Person licensed as an allopathic or osteopathic physician, or
- Practitioner defined as a physician assistant licensed, or
- Certified nurse practitioner.

Provider: A person or group who has an agreement with AHCCCS to provide services to AHCCCS members.

Rehabilitation Services and Devices: See **Rehabilitation**.

Rehabilitation: Services that help a person restore and keep skills and functioning for daily living that have been lost or impaired.

Skilled Nursing Care: Skilled services provided in your home or in a nursing home by licensed nurses or therapists.

Specialist: A doctor who practices a specific area of medicine or focuses on a group of patients.

Urgent Care: Care for an illness, injury, or condition serious enough to seek immediate care, but not serious enough to require emergency room care.

Maternity care service definitions

Certified Nurse Midwife (CNM) — An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

Free Standing Birthing Centers — Out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services (ADHS) and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses and maternity care providers to assist with labor and delivery services and are equipped to manage uncomplicated, low-risk labor and delivery. These facilities shall be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

High-Risk Pregnancy — Refers to a condition in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.

Licensed Midwife (LM) — An individual licensed by the Arizona Department of Health Services (ADHS) to provide maternity care as specified in A.R.S. Title 36, Chapter 6, Article 7 and A.A.C. R9-16. (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board.)

Maternity Care — Includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

Maternity Care Coordination — Consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.

Maternity Care Provider — The following are provider types who may provide maternity care when it is within their training and scope of practice:

1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers.
2. Physician Assistant(s).
3. Nurse Practitioners.
4. Certified Nurse Midwives, and
5. Licensed Midwives.

Postpartum — For individuals determined eligible for 12-months postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

Postpartum Care — For individuals determined eligible for 12-months postpartum coverage, postpartum care is health care provided for a period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum care is health care provided for a period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

Practitioner — Refers to certified nurse practitioners in midwifery, physician assistant(s) and other nurse practitioners. Physician assistant(s) and nurse practitioners are as specified in A.R.S. Title 32, Chapters 15 and 25, respectively.

Preconception Counseling — The provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.

Preconception counseling is considered included in the well-woman preventative care visit and does not include genetic testing.

Prenatal Care — The provision of health services during pregnancy which is composed of three major components:

1. Early and continuous risk assessment.
2. Health education and promotion.
3. Medical monitoring, intervention, and follow-up.

Contract services are funded under contract with the State of Arizona. UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 calendar days of when you found out about it. A decision will be sent to you within 30 calendar days. If you disagree with the decision, you have 15 calendar days to ask us to look at it again.

If you need help with your complaint, please call Member Services at **1-800-293-3740**, TTY **711**, 8 a.m.–5 p.m., Monday–Friday.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

If you need help with your complaint, please call Member Services at **1-800-293-3740**, TTY **711**.

Services to help you communicate with us are provided at no cost to members, such as other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-800-293-3740**, TTY **711**, 8 a.m.–5 p.m., Monday–Friday.

Health Plan Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2023

By law, we[1] must protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

- How we may use your HI.
- When we can share your HI with others.
- What rights you have to access your HI.

By law, we must follow the terms of this notice.

HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or e-mail. We will also post the new notice at this website **(www.uhccommunityplan.com)**. We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How we collect, use, and share your information

We collect, use, and share your HI with:

- You or your legal representative.
- Government agencies.

We have the right to collect, use and share your HI for certain purposes. This must be for your treatment, to pay for your care, or to run our business. We may use and share your HI as follows.

- **For Payment.** We may collect, use, and share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may collect, use, and share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.

- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** We may collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may collect, use and share your HI to send you appointment reminders and information about your health benefits.
- **For Communications to You.** We may use the phone number or email you gave us to contact you about your benefits, healthcare or payments.

We may collect, use, and share your HI as follows:

- **As Required by Law.**
- **To Persons Involved with Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

We will only use your HI as described here or with your written consent. We will get your written consent to share psychotherapy notes about you. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain promotional mailings. If you let us share your HI, the recipient may further share it. You may take back your consent. To find out how, call the phone number on your ID card.

Your rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request as allowed by state and federal law. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.

- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website **(www.uhccommunityplan.com)**.
- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using your rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or TTY/RTT **711**.
- **To Submit a Written Request.** Mail to:
  UnitedHealthcare Privacy Office
  MN017-E300, P.O. Box 1459, Minneapolis MN 55440
- **Timing.** We will respond to your phone or written request within 30 days.
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

You may also notify the Secretary of the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Financial Information Privacy Notice

THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. REVIEW IT CAREFULLY.

Effective January 1, 2023

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information we collect

- We get FI from your applications or forms. This may be name, address, age and social security number.
- We get FI from your transactions with us or others. This may be premium payment data.

Sharing of FI

We will only share FI as permitted by law.

We may share your FI to run our business. We may share your FI with our Affiliates. We do not need your consent to do so.

- We may share your FI to process transactions.
- We may share your FI to maintain your account(s).
- We may share your FI to respond to court orders and legal investigations.
- We may share your FI with companies that prepare our marketing materials.

Confidentiality and security

We limit employee and service provider access to your FI. We have safeguards in place to protect your FI.

Questions about this notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or TTY/RTT **711**.

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Life Print Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-293-3740**, TTY **711**. You can also visit our website at **UHCCommunityPlan.com**.

UnitedHealthcare Community Plan
1 East Washington, Suite 900
Phoenix, AZ 85004

UHCCommunityPlan.com

1-800-293-3740, TTY **711**

United Healthcare
Community Plan


United
Healthcare
Community Plan