

Temporary Hotel Assistance Request

T19 and NT19 Mercy Care RBHA Members with SMI



Must provide W-9 for Hotel Vendor

Send request to: smimemberservicesrequest@MercyCareAZ.org

Name:	Date of Request:
AHCCCS ID:	Date Service Needed:
Provider:	RBHA Health Home:
CM:	CD/SA:
Level of CM Service (e.g. ACT, Supp.):	
Initial request cannot exceed 7 days An extension can be submitted for an additional 7 days	
Date of Check-In:	Date of Check-Out:

Total Amount Requested (cannot exceed \$90 per night, not including taxes/fees): \$ _____

- 1) Current living situation:

- 2) Identified living situation post hotel stay:
 - Estimated date of move in (if applicable)

- 3) Confirmation member is able to live independently: Yes No

- 4) Confirmation member has a valid Arizona ID: Yes No

- 5) Confirmation vendor is able to accept a corporate check: Yes No

- 6) Community/alternate resources explored:

Reason for Request:

What current support is provided to the member (including formal and informal supports)? What support will be provided to the member during the hotel stay? Are supports currently in place or will be in place by check-in time?

SA/CD signature:

Date:

RD signature:

Date:

Attestation: By signing the above request form for hotel assistance, I certify that to the best of my knowledge, information, and belief that the information contained in the request form for hotel assistance concerning the functional area for which I am accountable is accurate, complete, and truthful.