# Temporary Extension Hotel Assistance Request

T19 and NT19 Mercy Care RBHA Members with SMI

Send request to: smimemberservicesrequest@MercyCareAZ.org

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|---|---|
| Name: | Date of Request: |
| AHCCCS ID: | Date Service Needed: |
| Provider: | RBHA Health Home: |
| CM: | CD/SA: |
| Level of CM Service (e.g. ACT, Supp.): | |
| **Extension request cannot exceed 7 days** | |
| Date of Original Check-In: | Updated Date of Check-Out: |

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

Number of requested extension days: _____

Reason for Extension Request:

What current support is provided to the member (including formal and informal supports)? Include start date of formal support(s) (if applicable):

What effort(s) has/have the clinical team exhausted to overcome barrier(s) with check-out?

SA/CD signature: _____ Date: _____

RD signature: _____ Date: _____

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

Updated 06/16/2022