Moving Assistance Request

T19 and NT19 Mercy Care RBHA Members with SMI

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.):	

Provide the reason for the move (why funding is needed/member is unable to pay the expense) and the approximate square footage, number of rooms, and/or roughly how many big/small items with which this member needs assistance:

Is this move to/from a storage facility? ☐ Yes ☐ No If yes, provide the location and hours of the storage facility:

Community/alternate resources explored:

What follow-up support with maintaining independent living will be provided to the member?

SA/CD signature: _____ Date: _____

RD signature: _____ Date: _____

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

Updated 06/16/2022