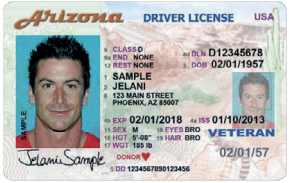
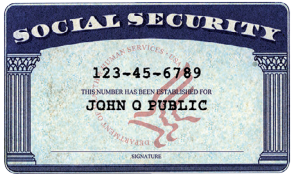
申请 AHCCCS 和/或费用减免计划所需的文件资料

带照片的身份证

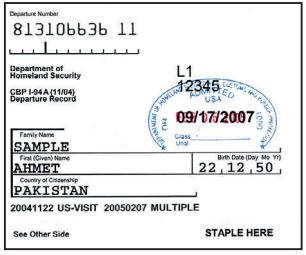


社会保障卡

（如适用）

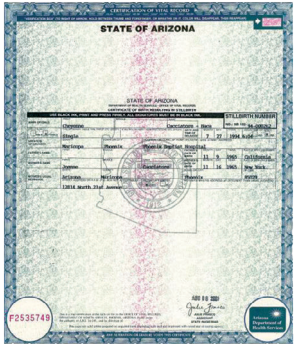


I-94

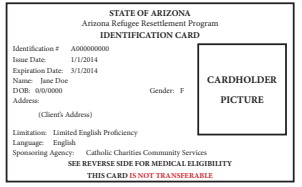


AHDC-015-CHINESE

出生证明



RMAP



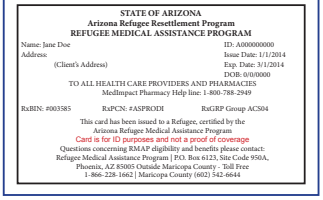
STATE OF ARIZONA
Arizona Refugee Resettlement Program
IDENTIFICATION CARD

Identification # A000000000
Issue Date: 1/1/2014
Expiration Date: 3/1/2014
Name: Jane Doe
DOB: 0/0/0000 Gender: F
Address:
(Client's Address)

CARDHOLDER PICTURE

Limitation: Limited English Proficiency
Language: English
Sponsoring Agency: Catholic Charities Community Services

SEE REVERSE SIDE FOR MEDICAL ELIGIBILITY
THIS CARD IS NOT TRANSFERABLE



STATE OF ARIZONA
Arizona Refugee Resettlement Program
REFUGEE MEDICAL ASSISTANCE PROGRAM

Name: Jane Doe
Address:
(Client's Address)
ID: A000000000
Issue Date: 1/1/2014
Exp. Date: 3/1/2014
DOB: 0/0/0000

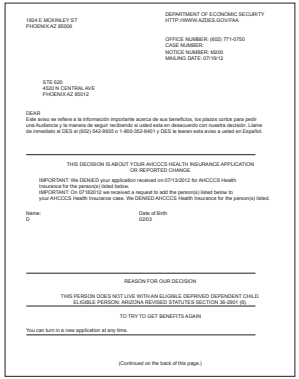
TO ALL HEALTH CARE PROVIDERS AND PHARMACIES
MedImpact Pharmacy Help-line: 1-800-788-2949

RxBIN: #003585 RxPCN: #ASPRODI RxGRP Group ACS04

This card has been issued to a Refugee, certified by the Arizona Refugee Medical Assistance Program
Card is for ID purposes and not a proof of coverage
Questions concerning RMAP eligibility and benefits please contact:
Refugee Medical Assistance Program | P.O. Box 6123, Site Code 950A, Phoenix, AZ 85005 Outside Maricopa County - Toll Free 1-866-228-1662 | Maricopa County (602) 542-6644

AHCCCS 拒绝信

（如果要申请费用减免计划）



1624 E MCKINLEY ST
PHOENIX AZ 85006

DEPARTMENT OF ECONOMIC SECURITY
HTTP://WWW.AZDES.GOV/FAA

OFFICE NUMBER: (602) 771-0750
CASE NUMBER:
NOTICE NUMBER: M200
MAILING DATE: 07/19/12

STE 620
4520 N CENTRAL AVE
PHOENIX AZ 85012

DEAR
Este aviso se refiere a la información importante acerca de sus beneficios, los plazos cortos para pedir una Audiencia y la manera de seguir recibiendo o cómo esto en desacuerdo con nuestra decisión. Llame de inmediato al DES al (602) 542-9935 o 1-800-352-8401 y DES le leerán esta aviso a usted en Español.

THIS DECISION IS ABOUT YOUR AHCCCS HEALTH INSURANCE APPLICATION OR REPORTED CHANGE

IMPORTANT: We DENIED your application received on 07/13/2012 for AHCCCS Health Insurance for the person(s) listed below.
IMPORTANT: On 07162012 we received a request to add the person(s) listed below to your AHCCCS Health Insurance case. We DENIED AHCCCS Health Insurance for the person(s) listed.

Name: Date of Birth
D 02/03

REASON FOR OUR DECISION

THIS PERSON DOES NOT LIVE WITH AN ELIGIBLE DEPRIVED DEPENDENT CHILD.
ELIGIBLE PERSON: ARIZONA REVISED STATUTES SECTION 36-2901 (6).

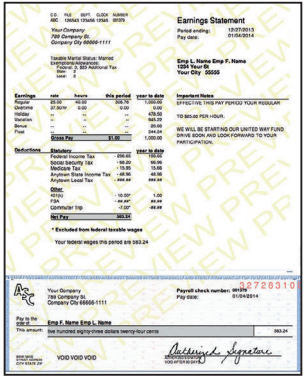
TO TRY TO GET BENEFITS AGAIN

You can turn in a new application at any time.

(Continued on the back of this page.)

收入证明

（过去 30 天的收入）



C.O. FILE DEPT CLOCK NUMBER
ABC 1000A3 1234B 12345 00123

Your Company
789 Company St.
Company City 00000-1111

Earnings Statement
Period ending: 12/27/2013
Pay date: 01/04/2014

Taxable Marital Status: Married
Exemptions/Allowances:
Federal: 2, $50 Additional Tax
State: 2
Local: 0

Emp L. Name Emp F. Name
1234 Your St
Your City 55555

Earnings	rate	hours	this period	year to date
Regular	20.00	40.00	800.00	11,000.00
Overtime	27.50*H	0.00	0.00	0.00
Holiday	--	--	--	478.00
Vacation	--	--	--	945.00
Bonus	--	--	--	50.00
Float	--	--	--	244.24
	Gross Pay		31.00	11,000.00

Deductions	Statutory	year to date
Federal Income Tax	-856.00	150.00
Social Security Tax	-50.20	66.96
Medicare Tax	-15.55	15.66
Arizona State Income Tax	-48.96	48.96
Arizona Local Tax	-44.44	44.44
Other		
401(k)	-10.00*	1.00
Cafe	-14.00*	44.44
Commuter Trip	-10.00*	48.48
Net Pay	560.32	

* Excluded from federal taxable wages

Your federal wages this period are 560.24

Important Notes
EFFECTIVE THIS PAY PERIOD YOUR REGULAR
TO $60.00 PER HOUR.
WE WILL BE STARTING OUR UNITED WAY FUND DRIVE SOON AND LOOK FORWARD TO YOUR PARTICIPATION.

32783310

Your Company
789 Company St.
Company City 66666-1111

Payroll check number: 99999
Pay date: 01/04/2014

Pay to the order of Emp F. Name Emp L. Name
This amount five hundred eighty-three dollars twenty-four cents 583.24

VOID VOID VOID

租房协议或水电气 账单

aps®

SRP

NATIVE HEALTH

Arizona Department of Health Services