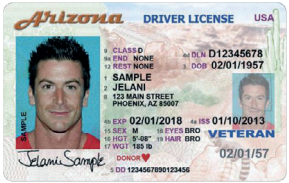
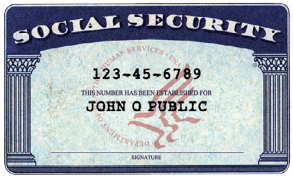
مدارک موردنیاز برای AHCCCS و یا جدول هزینه‌های متغیر (Sliding Fee Scale)

اجاره‌نامه یا قبض خدمات
(آب، گاز یا برق)

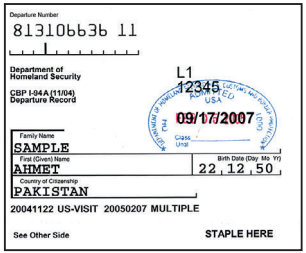
مدرک شناسایی عکس‌دار



کارت تأمین اجتماعی
(درصورت نیاز)

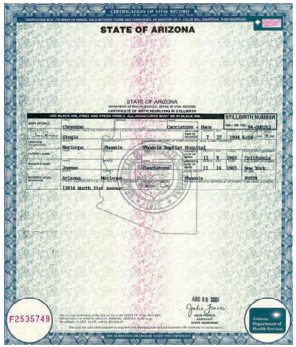


I-94



AHDC-015-FARSI

گواهی تولد



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

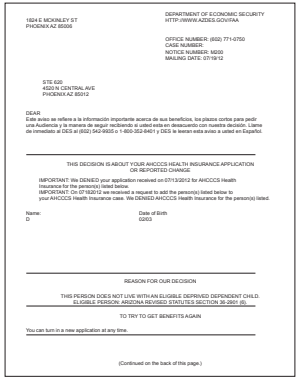
Name: Jane Doe
Address:
(Client's Address)
ID: A000000000
Issue Date: 1/1/2014
Exp. Date: 3/1/2014
DOB: 0/0/0000

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

نامه عدم‌پذیرش AHCCCS
(درصورت درخواست برای جدول هزینه‌های متغیر)


1624 E MOKINLEY 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 ayuda mientras 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

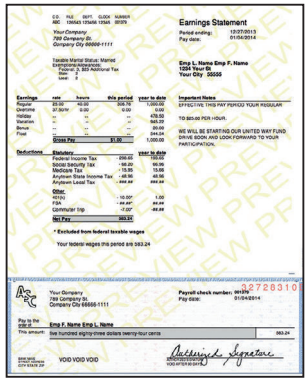
THIS PERSON DOES NOT LIVE WITH AN ELIGIBLE DEPRIVED DEPENDENT CHILD.
ELIGIBLE PERSON: ARIZONA REVISED STATUTES SECTION 36-2901 (6).

TO TRY TO GET BENEFITS AGAIN

You can turn in a new application at any time.

(Continued on the back of this page.)

گواهی درآمد
(مربوط به درآمد 30 روز گذشته)


Earnings Statement
Period ending: 12/07/2013
Pay date: 01/04/2014
Your Company
789 Company St.
Company City 66666-1111
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 1,000.00
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 1,000.00
Deductions Statutory year to date
Federal Income Tax -99.60 199.60
Social Security Tax -62.00 62.00
Medicare Tax -15.55 15.55
Arizona State Income Tax -48.90 48.90
Arizona Local Tax -44.44 44.44
Other
401(k) -10.00* 1.00
Cafeteria -44.44* 44.44
Commuter Trip -12.00* 48.48
Net Pay 660.32
* Excluded from federal taxable wages
Your federal wages this period are 563.24
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 six hundred eighty-three dollars twenty-four cents 683.24
VOID VOID VOID
Authorized Signature

NATIVE HEALTH

Arizona Department of Health Services