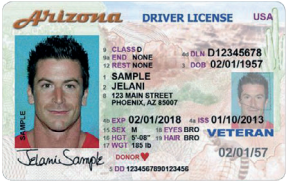
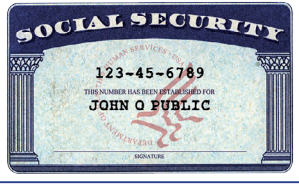
# Необходимые документы для AHCCCS и/или Оплаты по скользящей шкале

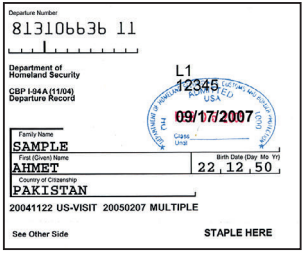
## Идентифицирующий документ с фотографией




## Карточка социального обеспечения (если применимо)

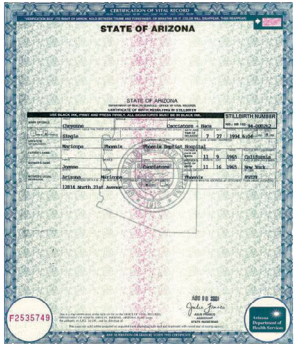



## I-94

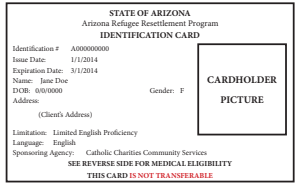



AHDC-015-RUSSIAN

## Свидетельство о рождении




## RMAP



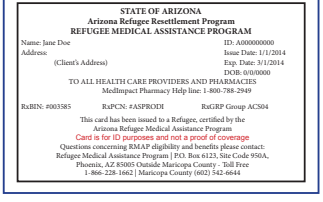
STATE OF ARIZONA
Arizona Refugee Resettlement Program
IDENTIFICATION CARD

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

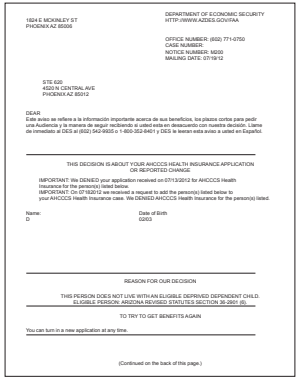
Name: Jane Doe
Address:
(Client's Address)
ID: A000000000
Issue Date: 1/1/2014
Exp. Date: 3/1/2014
DOB: 0/0/0000

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

## Письмо об отказе от AHCCCS (если обратились для Оплаты по скользящей шкале)



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 ayuda en espera de una 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: D
Date of Birth 02/03

REASON FOR OUR DECISION

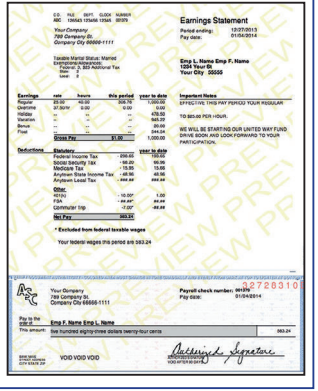
THIS PERSON DOES NOT LIVE WITH AN ELIGIBLE DEPRIVED DEPENDENT CHILD. ELIGIBLE PERSON: ARIZONA REVISED STATUTES SECTION 36-2901 (6).

TO TRY TO GET BENEFITS AGAIN

You can turn in a new application at any time.

(Continued on the back of this page.)

## Подтверждение дохода (за последние 30 дней дохода)



Earnings Statement
Period ending: 12/07/2013
Pay date: 01/04/2014

Your Company
789 Company St.
Company City 00000-1111

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

Important Notes
EFFECTIVE THIS PAY PERIOD YOUR REGULAR
TO $8.00 PER HOUR.
WE WILL BE STARTING OUR UNITED WAY FUND DRIVE SOON, AND LOOK FORWARD TO YOUR PARTICIPATION.

| Earnings | rate | hours | this period | year to date |
|---|---|---|---|---|
| Regular | 8.00 | 40.00 | 306.76 | 1,000.00 |
| Overtime | 37.50/hr | 0.00 | 0.00 | 0.00 |
| Holiday | -- | -- | -- | 478.00 |
| Vacation | -- | -- | -- | 945.00 |
| Bonus | -- | -- | -- | 85.00 |
| Float | -- | -- | -- | 244.24 |
| | | Gross Pay | 51.00 | 1,000.00 |

| Deductions | Statutory | | year to date |
|---|---|---|---|
| | Federal Income Tax | -$58.00 | 150.00 |
| | Social Security Tax | -$6.20 | 66.96 |
| | Medicare Tax | -$1.55 | 15.66 |
| | Arizona State Income Tax | -$8.96 | 48.90 |
| | Anytown Local Tax | -$44.44 | 444.44 |
| | Other | | |
| | 401(k) | -$0.00* | 1.00 |
| | Cafeteria | -$4.00* | 44.44 |
| | Commuter Trip | -$1.00* | 48.48 |
| | Net Pay | 360.32 | |

* Excluded from federal taxable wages

Your federal wages this period are $53.24

Your Company
789 Company St.
Company City 00000-1111

Payroll check number: 00256
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

Authorized Signature

## Договор аренды или счета за коммунальные услуги

aps®

SRP

NATIVE HEALTH

Arizona Department of Health Services