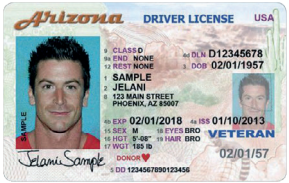
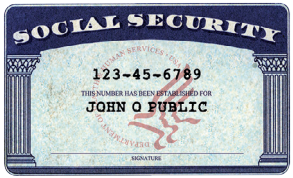
Documentos necesarios para AHCCCS y/o Escala de Pagos

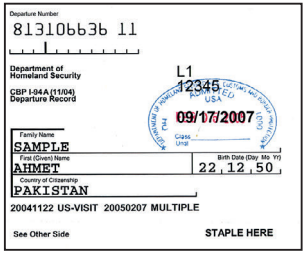
Identificación Con Foto



Tarjeta de Seguro Social
(si es aplicable)

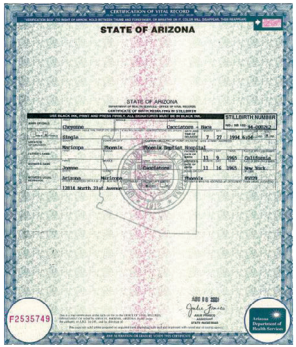


I-94



AHDC-015-SPANISH

Certificado de Nacimiento



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

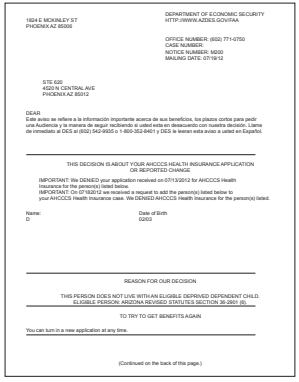
Name: Jane Doe
Address:
(Client's Address)
ID: A000000000
Issue Date: 1/1/2014
Exp. Date: 3/1/2014
DOB: 0/0/0000

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

Carta de negación de AHCCCS si estas aplicando para Escala de Pagos


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 a cuenta esto en desacuerdo con nuestra decisión. Llame de inmediato al DES al (602) 542-9935 o 1-800-352-8401 y DES le leeran 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

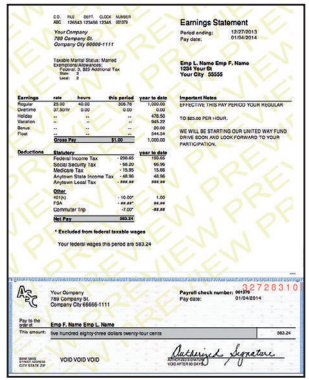
THIS PERSON DOES NOT LIVE WITH AN ELIGIBLE DEPRIVED DEPENDENT CHILD.
ELIGIBLE PERSON: ARIZONA REVISED STATUTES SECTION 36-2901 (6).

TO TRY TO GET BENEFITS AGAIN

You can turn in a new application at any time.

(Continued on the back of this page.)

Prueba de Ingresos
(de los últimos 30 días)


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 40.00 320.00 1,000.00
Overtime 12.00/hr 0.00 0.00 0.00
Holiday 470.00
Vacation 945.00
Bonus 50.00
Float 244.24
Gross Pay 31.00 1,000.00
Deductions Statutory year to date
Federal Income Tax -256.00 -550.00
Social Security Tax -80.20 -95.56
Medicare Tax -15.55 -15.55
Anytown State Income Tax -48.96 -48.96
Anytown Local Tax -444.44 -444.44
Other
401(k) -10.00* 1.00
Life -14.00* -44.44
Commuter Trip -12.00* -48.44
Net Pay 360.32
* Excluded from federal taxable wages
Your federal wages this period are 360.24
32783310
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 three hundred eighty-three dollars twenty-four cents 383.24
VOID VOID VOID
Nothing's Signature

Contrato de arrendamiento o actual factura de servicios públicos

aps®

SRP

NATIVE HEALTH

Arizona Department of Health Services