Neighborhood Outreach Access to Health

ARPA MCP Fee Waiver

Program Requirement Criteria Staff Validation

- ☐ Patient attested to be a City of Phoenix Resident.
- ☐ Residency attestation Form saved on File.
- ☐ Patient presented uninsured or underinsured.
- ☐ Has a Hx of Behavioral Health needs, problem, and or diagnosis.
- ☐ Referral to Community Resources has been placed for additional coverage opportunities.

Patient Name:	
Medical Record #:	
Address:	
City, State, Zip Code:	
Phone #:	
Provider Name:	
Clinic Site:	
Services provided:	
	☐ SDoH Screening and Assessment
	☐ SDoH navigation of resources
	☐ Covid Services
	☐ Behavioral Health
	☐ Public assistance program enrollment
	☐ Public assistance program assessment

I recommend patient for ARPA MCP Program. I have educated to patient any services outside of NOAH are not covered. If patient results ineligible for services under this fund, patient will be responsible for cost.

Requested By: _____ Date: _____

Reviewed By: _____ Date: _____

Approved By: _____ (Revenue Cycle) Date: _____

Please email completed form to: Noahcrmanagement@honorhealth.com