Individual Enrollment Request Form To Enroll Hamaspik Medicare Choice (HMO D-SNP) A Medicaid Advantage Plus Plan (MAP)

Who can use this form?

People with Medicare and Medicaid who want to join Hamaspik Medicare Choice. This plan is a Medicare Advantage Plan and Medicaid Advantage Plus Plan.

To join a MAP plan, you must:

- *Be a United States citizen or be lawfully present in the U.S.*
- *Live in the plan's service area*
- *Have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance)*
- *Have Medicaid in New York*
- *Be at least 18 years old or older*
- *Agree to enroll for your Medicare and Medicaid covered services*
- *Be eligible for nursing home level of care (based on an assessment conducted by a nurse);*
- *Be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to his/her health and safety, and*
- *Require care management and be expected to need at least one of the following services covered by MAP for at least 120 days from the effective date of enrollment;*
  - ✓ *nursing services in the home*
  - ✓ *therapies in the home;*
  - ✓ *home health aide services;*
  - ✓ *personal care services in the home;*

(continued on next page)

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- ✔ *consumer directed personal assistance services (CDPAS)*
- ✔ *adult day health care; or*
- ✔ *private duty nursing*

You can join a MAP plan at any time during the year. Your enrollment will usually begin on the first day of the month after you sign the enrollment form, if you sign the enrollment form before the 20th day of the month.

What do I need to complete this form?

- *Your Medicare Number (the number on your red, white, and blue Medicare card)*
- *Your Medicaid Number*
- *Your permanent address and phone number*

Note: *You must complete all items in Section 1.*

The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

You must also complete the Medicaid section of this enrollment application.

What happens next?

Send your completed and signed form to: *Hamaspik Medicare Select*
58 Route 59, Suite #1
Monsey, NY 10952

Once they process your request to join and it is approved by Medicare and Medicaid, we'll contact you to begin your MAP services.

How do I get help with this form?

Call Hamaspik Medicare Select at 888-426-2774. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: *Llame a Hamaspik Medicare Select al 888-426-2774. TTY: 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.*

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Hamaspik Medicare CHOICE

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

◯ *Hamaspik Medicare Choice - $0 per month*

FIRST Name:	*LAST Name:*	*(OPTIONAL) Middle Initial:*
Birth Date: MM / DD / YYYY	*Sex:* ◯ *Male* ◯ *Female*	*Phone Number:*
Permanent Residence street address (P.O. Box is not allowed):		
Address:		

City:	*County:*	*State:*	*Zip Code:*
Mailing address, if different from your permanent address (P.O. Box is allowed):			
Address:	*City:*	*State:*	*Zip Code:*

Your Medicare Information

Medicare Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Hamaspik Medicare Choice?

◯ *Yes* ◯ *No*

Name of Other Coverage:

Member Number of Other Coverage:

Group Number of Other Coverage:

Do you have Medicaid in New York State? ◯ *Yes* ◯ *No*

Hamaspik Medicare CHOICE

IMPORTANT:
Read and sign below

- *I must keep both Hospital (Part A) and Medical (Part B) to stay in Hamaspik Medicare Choice.*
- *By joining this Medicare Advantage Plan, I acknowledge that Hamaspik Medicare Choice will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).*
- *Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.*
- *I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).*
- *The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.*
- *I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.*
- *I understand that when my Hamaspik Medicare Choice coverage begins, I must get all of my medical and prescription drug benefits from Hamaspik Medicare Choice. Benefits and services provided by Hamaspik Medicare Choice and contained in my Hamaspik Medicare Choice "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare, Medicaid nor Hamaspik Medicare Choice will pay for benefits or services that are not covered.*
- *I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:*
  1. *This person is authorized under State law to complete this enrollment,*
  2. *Documentation of this authority is available upon request by Medicare.*

Signature:	*Today's Date:*
If you're the authorized representative, sign above and fill out these fields:	
Name:	*Address:*
Phone Number:	*Relationship to Enrollee:*

Hamaspik Medicare CHOICE

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ◯ *No, not of Hispanic, Latino/a, or Spanish origin*
- ◯ *Yes, Mexican, Mexican American, Chicano/a*
- ◯ *Yes, Puerto Rican*
- ◯ *Yes, Cuban*
- ◯ *Yes, another Hispanic, Latino/a, or Spanish origin*
- ◯ *I choose not to answer*

What's your race? Select all that apply.

- ◯ *American Indian or Alaska Native*
- ◯ *Asian Indian*
- ◯ *Black or African American*
- ◯ *Chinese*
- ◯ *Filipino*
- ◯ *Guamanian or Chamorro*
- ◯ *Japanese*
- ◯ *Korean*
- ◯ *Native Hawaiian*
- ◯ *Other Asian*
- ◯ *Other Pacific Islander*
- ◯ *Samoan*
- ◯ *Vietnamese*
- ◯ *White*
- ◯ *I choose not to answer*

Select one if you want us to send you information in a language other than English.

◯ *Spanish*

Select one if you want us to send you information in an accessible format.

◯ *Braille* ◯ *Large Print* ◯ *Audio CD*

Please contact Hamaspik Medicare Choice at 1-833-426-2774 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2020 through March 31, 2021. From April 2021 through September 2021, our Member Service Department will be available Monday thru Friday, 8:00 am to 8:00 pm. TTY users should call 711.

Do you work? ◯ *Yes* ◯ *No*

Does your spouse work? ◯ *Yes* ◯ *No*

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. (Select one or more.)

◯ *Evidence of Coverage* ◯ *Provider and Pharmacy Directory* ◯ *Formulary (List of Covered Drugs)*

Email: _____

These documents are also available on our website at www.hamaspik.com.

Hamaspik Medicare Choice (HMO DSNP)
A Medicaid Advantage Plus Plan (MAP)

Medicaid Enrollment Agreement

1. *I wish to enroll in the Hamaspik Medicare Choice (MAP plan) and understand that enrollment is voluntary.*
   ◯ *Yes* ◯ *No*

2. *I have received and have had the Member Handbook explained to me, which includes the rules and responsibilities of plan membership and a description of covered and non-covered services.*
   ◯ *Yes* ◯ *No*

3. *I agree to participate in the Hamaspik Medicare Choice (MAP plan) according to the terms and conditions described in the Member Handbook.*
   ◯ *Yes* ◯ *No*

4. *I understand that I may choose to disenroll from Hamaspik Medicare Choice (MAP plan) by giving written or oral notice and Hamaspik Medicare Choice will notify me of the effective date of disenrollment.*
   ◯ *Yes* ◯ *No*

5. *As an enrollee, I agree to receive all covered services from Hamaspik Medicare Choice (MAP Plan) Provider Network. I have received a copy of the Provider Network Directory.*
   ◯ *Yes* ◯ *No*

6. *If I am or become a resident in a nursing facility, I agree to a referral to New York State's contractor for Money Follows the Person/Open Doors, a program that can work with my MLTC plan to help me return to community living.*
   ◯ *Yes* ◯ *No*

7. *I understand that my date of enrollment is expected to be _____.*
   ◯ *Yes* ◯ *No*

8. *I understand that if I have a Medicaid Spenddown/Surplus as a condition of my Medicaid eligibility, I agree to pay Spenddown/Surplus to Hamaspik MAP.*
   ◯ *Yes* ◯ *No*

9. *I understand that my Enrollment Application must be confirmed by New York Medicaid Choice.*
   ◯ *Yes* ◯ *No*

Hamaspik Medicare CHOICE

Signature Page:

Enrollee Name (print)	*Signature of Enrollee*	*Date*
Name of Legal Rep. (If applicable)	*Signature of Legal Rep.*	*Date*
Witness Name	*Signature of Witness*	*Date*
Hamaspik Assessment Nurse	*Signature of Hamaspik Nurse*	*Date*

For enrollees who do not speak English as a first language:

I, _____ , have read and translated this enrollment agreement in the primary language that _____ speaks.

(Name of member)

Signature of Translator _____ Date _____

Services Consent
Release Of Information/Acknowledgement

Member: _____

- ◯ *I authorize Hamaspik Medicare Choice staff to provide services, as requested by myself or my representative, and ordered by my physician.*
- ◯ *The services provided which Hamaspik Medicare Choice will provide have been explained to me and, I understand that I may refuse treatment within the confines of the law after being informed of the consequences of my action.*
- ◯ *I authorize Hamaspik Medicare Choice and other licensing/regulatory bodies to periodically examine my medical record for the purpose of checking compliance to applicable rules, regulations, and standards.*
- ◯ *I understand that it would be prudent and in my best interests to establish a Home Health Service Plan of Care in the event of an emergency such as a fire, hurricane, severe snowstorm, or other natural disaster. Therefore, I hereby grant Hamaspik Medicare Choice permission to disclose to any governmental agency, supplemental provider agency, community volunteer service, or any other providers of services, my medical records regarding my nursing care, except where otherwise prohibited by law. I further understand this would be done as necessary, upon request, in order to insure a safe and effective emergency preparedness plan of care.*
- ◯ *I authorize the New York State Department of Health to provide Hamaspik Medicare Choice with access to copies of information about my Medicaid eligibility status; and my files including Medicaid applications, re-certification information, notices and requests for information, and required documentation.*
- ◯ *I and/or my responsible party also agree to provide Hamaspik Medicare Choice with a copy of all notices about my Medicare or Medicaid eligibility within three days of receipt of such notice.*
- ◯ *I and/or my responsible party agree to provide complete and accurate financial information to Hamaspik Medicare Choice in a timely fashion.*

- ◯ *I give my consent and authorization for release of medical information to Hamaspik Medicare Choice by my physician(s) and other health care providers and facilities.*
- ◯ *I authorize Hamaspik Medicare Choice to release medical and financial information about me that is necessary for Hamaspik Medicare Choice to obtain payment for the services provided to me and to disclose and exchange personal information between my county's Department of Social Services, Maximus, and the New York State Department of Health and its agents.*
- ◯ *I acknowledge receiving verbal and written information concerning my Rights and Responsibilities as a Medicaid Advantage Plus (MAP) member, and the New York State Health Proxy Law/Advance Directives. In addition, Hamaspik Medicare Choice has provided a written procedure for submitting complaints and concerns, and directions regarding contacting the agency after hours, on weekends and holidays.*
- ◯ *I acknowledge receipt of the list of available Managed Long Term Care Plans in my area.*
- ◯ *I acknowledge receiving a copy of Hamaspik MAP's Notice of Privacy Practices.*

Member or Representative Signature: _____

Hamaspik Medicare CHOICE

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◯ *Spanish*

Select one if you want us to send you information in an accessible format.

◯ *Braille* ◯ *Large Print* ◯ *Audio CD*

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Do you work? ◯ *Yes* ◯ *No*	*Does your spouse work?* ◯ *Yes* ◯ *No*

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. (Select one or more.)

◯ *Evidence of Coverage* ◯ *Provider and Pharmacy Directory* ◯ *Formulary (List of Covered Drugs)*

Email: _____

These documents are also available on our website at www.hamaspik.com.

Paying your plan premiums

There is no plan premium in Hamaspik Medicare Choice.
If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must continue to pay this extra amount. *The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Hamaspik Medicare Choice the Part D-IRMAA.*

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.