SOUTH COUNTRY
HEALTH ALLIANCE
Bringing Wellness Home

SingleCare/SharedCare (SNBC MA37)
2019 Enrollment Form

South Country Health Alliance Member Services

1-866-567-7242. TTY for the hearing impaired at 1-800-627-3529 or 711

Hours of service are:
8 a.m. to 8 p.m., Monday through Friday

The call is free.

You can speak to someone about getting this information for free in other languages. Call 1-866-567-7242. TTY users should call 1-800-627-3529 or 711. Hours of service are 8 a.m. to 8 p.m., Monday through Friday. The call is free.

Return the completed form, pages 7 and 8, to:

South Country Health Alliance
2300 Park Drive, Suite 100
Owatonna, MN 55060

Fax: 507-431-6328

SCHA Member Services 1-866-567-7242, TTY 1-800-627-3529 or 711

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်၊ ဖဲနမ့်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်, ကိးဘဉ်လီတဲစိနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တက့်၊.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ, ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. South Country Health Alliance (SCHA) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Auxiliary Aids and Services: SCHA provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** SCHA Member Services at members@mnscha.org or call 1-866-567-7242 (toll free), TTY 1-800-627-3529 or 711.

Language Assistance Services: SCHA provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** SCHA Member Services at members@mnscha.org or call 1-866-567-7242 (toll free), TTY 1-800-627-3529 or 711.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by SCHA. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex

Contact the **OCR** directly to file a complaint:

Director
U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice)
800-537-7697 (TDD)
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)
You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

SCHA Complaint Notice

You have the right to file a complaint with SCHA if you believe you have been discriminated against because of any of the following:

- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information
- disability (including mental or physical impairment)
- marital status
- age
- sex (including sex stereotypes and gender identity)
- sexual orientation
- national origin
- race
- color
- religion
- creed
- public assistance status
- political beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Attn: Civil Rights Coordinator
South Country Health Alliance
2300 Park Drive, Suite 100
Owatonna, MN 55060
Toll Free: 866-567-7242
TTY: 800-627-3529 or 711
Fax: 507-444-7774
Email: grievances-appeals@mnscha.org

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

SCHA LB/CB-4068

INSTRUCTIONS for filling out the **SingleCare/Shared Care (SNBC MA37)** Enrollment Form

Please print as neatly as possible. Please fill in the following information on your enrollment form.

1	Name: Gender:	Write your name (last name, first name, middle initial). Check the box indicating if you are male or female.
2	Birth Date: Social Security Number: Phone Number:	Write the month, day, and year you were born. Write in the number as it appears on your Social Security card. You do not have to complete this field if you choose not to. Write the telephone number where you can be reached during the day.
3	Street address (where you live):	Write in the permanent address where you live, including street address, city, county, state, and zip code (no P.O. boxes).
4	Mailing Address: Email Address:	Write the street address or P.O. box where you get your mail if different from where you live. Write the email address where you can be contacted. You do not have to complete this field if you choose not to.
5	Medical Assistance ID number: Case Number: Are you pregnant?	Write in the number as it appears on your Minnesota Health Care Programs card. Write your Medical Assistance case number. If you are pregnant, check “Yes.” If you are not pregnant, check “No.”
6	Do you need an interpreter?	Check “Yes” or “No.” If you answer “Yes,” check the box for the language needed on the list.
7	Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT) or are you enrolled in the Developmental Disability waiver?	If you have been certified as disabled through the Social Security Administration, the State Medical Review team, or are enrolled in the Developmental Disability waiver, check “Yes.” If you have not been certified as disabled through the Social Security Administration, the State Medical Review team, or are not enrolled in the Developmental Disability waiver, check “No.”
8	Do you have Medicare coverage? Medicare Number: Effective Date Hospital (Part A): Effective Date Hospital (Part B):	Check “Yes” or “No.” If you answered “Yes”: Take out your Medicare card to complete this section. Write your Medicare number as it appears on your red, white, and blue card (not your Social Security card). Write in the effective date for Hospital (Part A) as it appears on your card. Write in the effective date for Medical (Part B) as it appears on your card.
9	Do you have End-Stage Renal Disease (ESRD)? If “Yes”, date dialysis started:	End Stage Renal Disease means you have kidney failure. If you have End Stage Renal Disease, check: “Yes” or “No.” If you answered “Yes”, add the date that you started dialysis.
10	Do you have other medical coverage? Name of your insurance company: Policy holder’s name: Group number: Policy number: Is this insurance through an employer?	Some people have other medical coverage. If you have other medical coverage, check “Yes.” If you do not have other health care coverage, check “No.” If you have other medical coverage, write in the name of the insurance company. Write the name of the policy holder. Write in the group number from this plan. Write in the policy number. If this insurance is through an employer, check “Yes.” If it is not through an employer, check “No.”
11	Primary care clinic you are choosing: Primary care clinic (PCC) number:	Go the the health plan’s ***Provider Directory***. Write the name of the primary care provider, clinic, or health center that you are choosing. Our ***Provider Directory*** can be found on our website at www.mnscha.org. Go to the health plan’s ***Provider Directory***. Write the number of the primary care provider, clinic, or health center that you are choosing.

Page 8 should be signed and filled out by you or your authorized representative.

When the form is completed, mail or fax pages 7 and 8 to South Country Health Alliance. Our address and fax number are on the cover.

SOUTH COUNTRY HEALTH ALLIANCE

OFFICE USE ONLY - DATE STAMP AREA - OFFICE USE ONLY - DATE STAMP AREA - OFFICE USE ONLY - DATE STAMP AREA - OFFICE USE ONLY - DATE STAMP

Office Use Only
Date: _____
Name of Authorized Sales Person_____
Effective Date of Enrollment _____
LIS Co-pay Level_____ LIS Co-pay Eff Date
Tracking # _____
Approved By _____

2019 SingleCare/SharedCare (SNBC MA37) Enrollment Request Form

1	LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER: ☐ Male ☐ Female
2	BIRTH DATE: (/ /) MM DD YYYY	SOCIAL SECURITY NUMBER (Optional): _____ – _____ – _____	PHONE NUMBER: (_____) _____ – _____	

3	STREET ADDRESS (where you live-PO Box not allowed):			
	CITY:	STATE:	ZIP CODE:	COUNTY:
4	MAILING ADDRESS (if different from where you live):			
	CITY:	STATE:	ZIP CODE:	COUNTY:
	E-MAIL ADDRESS (OPTIONAL):			

5	MEDICAL ASSISTANCE ID NUMBER:	CASE NUMBER:	ARE YOU PREGNANT? ☐ Yes ☐ No

6 DO YOU NEED AN INTERPRETER? ☐ Yes ☐ No If "Yes," check one of the boxes below:

☐ Spanish (01) ☐ Hmong (02) ☐ Vietnamese (03) ☐ Khmer (Cambodian) (04)
☐ Lao (05) ☐ Russian (06) ☐ Somali (07) ☐ ASL (American Sign Language) (08)
☐ Arabic (09) ☐ Serbo-Croatian/Bosnian (11) ☐ Oromo (12) ☐ Other (98), explain _____

7 DO YOU HAVE A DISABILITY that has been certified by the Social Security Administration or State Medical Review Team (SMRT) or are you enrolled in the Developmental Disability waiver? ☐ Yes ☐ No

8 DO YOU HAVE MEDICARE COVERAGE? ☐ Yes ☐ No If "yes" complete the information below

MEDICARE CLAIM (ID) NUMBER:	Hospital (Part A) Begin Date:	Medical (Part B) Begin Date:

9 DO YOU HAVE END-STAGE RENAL DISEASE (Optional): ☐ Yes ☐ No If "Yes" date dialysis started: _____

If you have answered "Yes" to this question and you do not need regular dialysis any more or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

10 Some individuals may have other medical coverage, including other private insurance.
DO YOU HAVE OTHER MEDICAL COVERAGE? ☐ Yes ☐ No

If **YES**, INSURANCE COMPANY NAME:	POLICY HOLDER'S NAME:
	GROUP NUMBER:
Is this insurance through an employer? ☐ Yes ☐ No	POLICY NUMBER:

CHOOSE HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Remember, joining SNBC is voluntary. You can always request to drop out and change back to Medical Assistance (Medicaid) fee-for-service effective the next available month.

11	PRIMARY CARE CLINIC YOU ARE CHOOSING:	PRIMARY CARE CLINIC (PCC) NUMBER:

Please read and sign the back of this form.

4407

Under South Country Health Alliance, I understand that:

South Country Health Alliance will be providing my health care covered by Medical Assistance (Medicaid).
Once I am a member of **South Country Health Alliance**, I have the right to appeal any services that are being denied, reduced, or stopped, or if **South Country Health Alliance** is denying payment for services.
I will be notified of the date my coverage will start.
On the date **South Country Health Alliance** coverage begins, I must get my health care from **South Country Health Alliance** doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get South Country Health Alliance approval to see other providers in some circumstances.
I will read the Member Handbook I get from **South Country Health Alliance**. It will have the rules I must follow and more information about the services my plan covers. Services contained in South Country Health Alliance's Member Handbook will be covered.
Some services require authorization from **South Country Health Alliance**. Without authorization, **South Country Health Alliance** will not pay for these services.
My **South Country Health Alliance** benefits **cannot** be canceled because I get sick or use health care services.
I can choose to leave **South Country Health Alliance** and change back to Medical Assistance (Medicaid) fee-for-service, effective the following month. I understand that I will be enrolled in **South Country Health Alliance** through the last day of the month.
My health care services will be coordinated through **South Country Health Alliance**. I may have to choose a primary care clinic.
To be enrolled and stay enrolled in **South Country Health Alliance**, I must: • Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT) or be enrolled in the Developmental Disability waiver • Be at least 18 years old and under 65 years old • Be eligible for Medical Assistance (Medicaid) without a medical spenddown • Either have no Medicare, **OR** have **both** Medicare Parts A **and** B • Live in a county serviced by **South Country Health Alliance** If this changes, I will notify my county worker and **South Country Health Alliance** so I can disenroll.
If I get a medical spenddown while enrolled in SNBC and **do not pay it to DHS**, I will be disenrolled from **South Country Health Alliance.**
If you are on Medical Assistance (Medicaid) for Employed Persons with Disabilities (MA-EPD), you must continue to pay your MA-EPD premium to remain eligible for Medical Assistance (Medicaid).

By enrolling in South Country Health Alliance, I authorize:

The sharing of information about my Medical Assistance (Medicaid) eligibility status and the information on this form among the state, its representatives, the county where I live, and **South Country Health Alliance**.
The information on this enrollment form is correct to the best of my knowledge.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this form means that I have read and understand the contents of the form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized by state law to complete this enrollment form on my behalf, and 2) documentation of this authority is available upon request by the state or South Country Health Alliance.

Signature of enrollee or authorized representative:		Date:
If you are the authorized representative, you must sign above and provide the following information		
Name (print):	Relationship to enrollee:	Phone number:
Street Address:		
City:	State:	Zip: