SOUTH COUNTRY
HEALTH ALLIANCE
Bringing Wellness Home

AbilityCare (HMO SNP)
2019 Enrollment Form

South Country Health Alliance Member Services

1-866-567-7242 ◆ TTY 1-800-627-3529 or 711

Hours of service are:
October - March, 7 days a week, 8 a.m. - 8 p.m;
April - September, Monday - Friday, 8 a.m. - 8 p.m.

The call is free.

Return the completed form, pages 1 to 4, to:

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

Fax: 507-431-6328

Please contact AbilityCare at the number listed above if you need information in another language or format.

AbilityCare (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance Program (Medicaid) to provide benefits of both programs to enrollees. Enrollment in AbilityCare depends on contract renewal.

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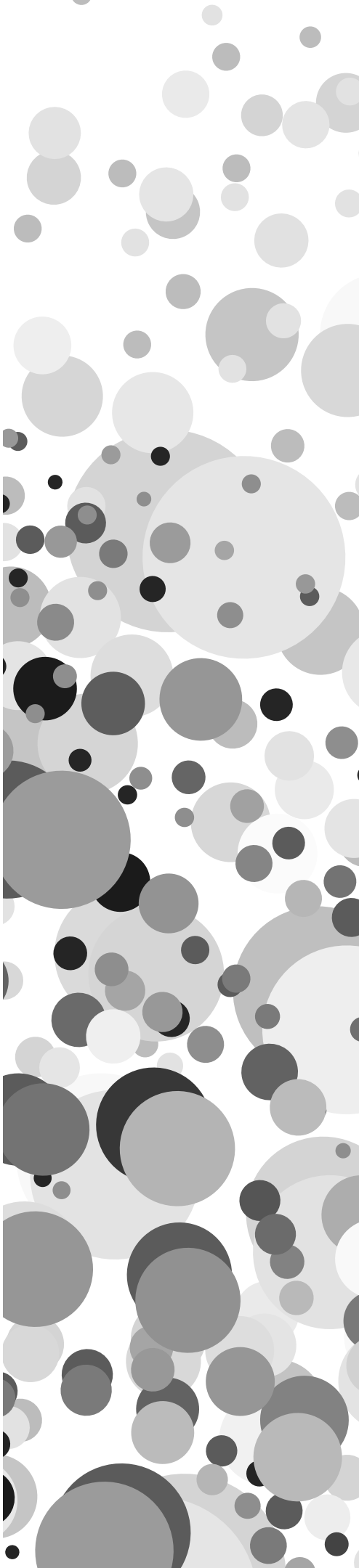

SCHA Member Services 1-866-567-7242, TTY 1-800-627-3529 or 711

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.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မ၊စ၊၊်ကလီလ၊တ၊်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်, ကိးဘဉ်လီတဲစိနီ၊်ဂံ၊်လ၊ထးအံၤန့ဉ်တကွ၊်.

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. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. 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.

INSTRUCTIONS

For filling out the **AbilityCare** Enrollment Form

Please print as neatly as possible. Please fill in the following information by numbered line on our enrollment form.

1	Name:	Write your name (last name, first name, middle initial).
2	Birth Date: Sex: Phone Number: Alternate Phone Number:	Write the month, day, and year you were born. Check the box indicating if you are male or female. Write the telephone number where you can be reached during the day. Write another phone number where you can be reached.
3	Permanent residence street address:	Write in the permanent address where you live, including street address, city, county, state, and zip code (no P.O. boxes).
4	Mailing Address:	Write the address where you receive your mail, if different from your permanent street address.
5	Email Address:	Write in the email address.
6	Medicare Number: Effective Date Hospital (Part A): Effective Date Hospital (Part B):	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.
7	Medical Assistance ID number:	Write in your Medical Assistance number.
8	Are you a resident in a long-term care facility?	If you now live in a long-term care facility, such as a nursing home or ICF-DD, check “Yes.” and write in the name and phone number. If you do not, check “No.”
9	Name of the primary care clinic/care system you are choosing: Code for the primary care provider, clinic, or health center you are choosing:	Go to the health plan’s ***Provider and Pharmacy Directory*** in your information packet. Write in the primary care clinic/care system/medical home that you are choose. Write the code of the primary care clinic/care system/medical home that you choose, located in the ***Provider and Pharmacy Directory***.
10	Do you need an interpreter?	Check “Yes” or “No.” If you answer “Yes,” circle the code of the language needed on the list.
11	1. Medical Spenddown?	Check “Yes” or “No.”
	2. Certified Disability?	Check “Yes” or “No.”
	3. End Stage Renal Disease?	Check “Yes” or “No.”
	4. Other prescription drug coverage?	If you answered “Yes” to this question, please fill out the name of other coverage, the ID number, and Group number.
	5. Health insurance through an employer?	If you answered “Yes” to this question, please fill out the employer name, policy holder’s name, and policy number.

Page 4 should be signed and filled out by you or your authorized representative.

When the form is complete, mail or fax pages 1 to 4 to South Country Health Alliance. Our address and fax number are on the cover.

Member Name: _____ Medical Assistance ID # _____

2019 AbilityCare (HMO SNP) Enrollment Request Form

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

Please contact AbilityCare if you need information in another language or format (*such as large print or Braille*).

To enroll in AbilityCare, please provide the following information:

1	LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	☐ Mr. ☐ Mrs. ☐ Ms.
2	BIRTH DATE: ( ) MM / DD / YYYY	SEX: ☐ Male ☐ Female	HOME PHONE NUMBER: (___) _____ – _____	ALTERNATE PHONE NUMBER: (___) _____ – _____
3	PERMANENT RESIDENCE STREET ADDRESS (P.O. Box is not allowed):			
	CITY:	COUNTY:	STATE:	ZIP CODE:
4	MAILING ADDRESS (only if different from your Permanent Residence Address) STREET ADDRESS:			
	CITY:		STATE:	ZIP CODE:
5	E-MAIL ADDRESS (OPTIONAL):			

6 Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

7	Please provide your Medical Assistance ID number (as it appears on your Minnesota Health Care Programs card):	
8	ARE YOU A RESIDENT IN A LONG-TERM CARE FACILITY SUCH AS A NURSING HOME? ☐ Yes ☐ No If "Yes," please provide the following information:	
	NAME OF THE FACILITY:	PHONE NUMBER: (_____) _____ – _____
9	NAME OF THE PRIMARY CARE CLINIC/CARE SYSTEM you are choosing:	PRIMARY CARE CLINIC/CARE SYSTEM ID NUMBER found in the ***Provider and Pharmacy Directory***:

CLEAR FORM

Member Name: _____Medical Assistance ID # _____

10	DO YOU NEED AN INTERPRETER? ☐ Yes ☐ No If "Yes," CIRCLE correct language (01) Spanish (02) Hmong (03) Vietnamese (04) Khmer (Cambodian) (05) Lao (06) Russian (07) Somali (08) ASL (American Sign Language) (10) Arabic (11) Serbo-Croatian/ Bosnian (12) Oromo (98) Other _____
11	**Please read and answer these important questions:**
	1. DO YOU HAVE A MEDICAL SPENDDOWN? ☐ Yes ☐ No
	2. DO YOU HAVE A DISABILITY that has been certified by the Social Security Administration or State Medical Review Team (SMRT)? ☐ Yes ☐ No
	3. DO YOU HAVE END-STAGE RENAL DISEASE (ESRD)? ☐ Yes ☐ No If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
	4. Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage, or VA benefits. WILL YOU HAVE OTHER PRESCRIPTION DRUG COVERAGE IN ADDITION TO ABILITYCARE? ☐ Yes ☐ No If "yes", please list your other coverage and your identification (ID) number(s) for this coverage below:
	NAME OF OTHER COVERAGE: / ID NUMBER: / GROUP NUMBER:
	5. DO YOU OR YOUR SPOUSE HAVE HEALTH INSURANCE, INCLUDING THROUGH A PREVIOUS OR CURRENT EMPLOYER? ☐ Yes ☐ No If yes, please list the insurance information below:
	EMPLOYER AND/OR INSURER NAME: / POLICY HOLDER'S NAME: / POLICY NUMBER:
	6. Please check one of the boxes below of you would prefer us to send you information in a language other than English or in an accessible format. ☐ Other Language (see #9- Do you need an interpreter?) ☐ Large print Please contact AbiltyCare at 1-866-567-7242 if you need information in an accessible format or language other than what is listed above. Or office hours are 8 a.m. to 8 p.m., Monday - Friday (April - September); 8 a.m. to 8 p.m., 7 days a week (October - March). TTY users should call 1-800-627-3529 or 711.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining AbilityCare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AbilityCare.
Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Member Name: _____Medical Assistance ID # _____

PLEASE READ AND SIGN ON PAGE 4.

By completing this enrollment application, I agree to the following:

- **AbilityCare** is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B.
- **AbilityCare** will be providing coverage for my care covered by Medicare and Medical Assistance.
- I can be in only one (1) Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future.
- To be enrolled and stay enrolled in **AbilityCare**, I must meet all the following criteria:
  - Be at least 18 and under age 65
  - Have a certified disability through the Social Security Administration or the State Medical Review Team
  - Be eligible for Medical Assistance without a Medical Spenddown
  - Have Medicare Parts A and B
  - Live in the **AbilityCare** service area.
- If any of this changes, I will notify **AbilityCare** so I can disenroll and find a new plan.
- Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstance. I understand that I will be enrolled in AbilityCare through the last day of the month. I understand that I will be automatically enrolled in Medical Assistance fee-for-service unless I am otherwise required to enroll in Families and Children or Minnesota Senior Care Plus (MSC+).
- Once I am a member of AbilityCare, I have the right to appeal plan decisions about payment or services if I disagree**.**
- I will read the ***Evidence of Coverage*** from AbilityCare to know which rules I must follow to get coverage with this Medicare Advantage plan.
- I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border**.**
- I understand that beginning on the date AbilityCare coverage begins, I must get all of my health care from AbilityCare network providers, except for emergency or urgently needed services, out-of-area or out-of-network dialysis services, open access services, or any other services previously authorized. Services authorized by AbilityCare and other services contained in my AbilityCare ***Evidence of Coverage*** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR ABILITYCARE WILL PAY FOR THE SERVICES.
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with AbilityCare, he/she may be paid based on my enrollment in AbilityCare.

Release of information: By joining **AbilityCare**, I acknowledge that:

- AbilityCare will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.
- AbilityCare will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- 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 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 application means that I have read and understand the contents of this application. 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, and
2. Documentation of this authority is available upon request from Medicare.

When you sign this form, it means that you understand the information you read.

_____
NAME OF APPLICANT (PLEASE PRINT)

_____ _____
SIGNATURE TODAY'S DATE

IF YOU ARE THE AUTHORIZED REPRESENTATIVE, you must sign above and provide the following information:

_____ _____
NAME (PRINT) RELATIONSHIP TO ENROLLEE

_____ _____
ADDRESS (PRINT) PHONE NUMBER

When the form is complete, mail or fax pages 1 to 4 to South Country Health Alliance. Our address and fax number are on the cover.

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 _____