Hennepin Health

Hennepin Health Enrollment Form

Hennepin Health Enrollment Telephone Numbers
Hennepin Health–SNBC Member Services Telephone Numbers
612-596-1036 or 1-800-647-0550. TTY for the hearing impaired at 1-800-627-3529. Monday – Friday, 8:00 a.m. – 4:30 p.m. The call is free.

Hennepin Health Member Services Telephone Numbers
612-596-1036 or 1-800-647-0550. TTY for the hearing impaired at 1-800-627-3529. Monday – Friday, 8:00 a.m. – 4:30 p.m. You can speak to someone about getting this information for free in other languages. Call 612-596-1036 or 1-800-647-0550. TTY/TDD users should call 1-800-627-3529, Monday – Friday, 8:00 a.m. – 4:30 p.m. The call is free.

Return the completed form, pages 1 to 3, to: Hennepin Health
Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, MN 55415

For accessible formats of this publication or assistance with additional equal access to our services, write to hennepinhealth@hennepin.us, call 612-596-1036 use your preferred relay service.

DHS approved 2/7/2019
MA-0048-MC

Hennepin Health Toll Free 1-800-647-0550 TTY 1-800-627-3529

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၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဇဉ်လ်ာ် တီလ်ာ်မီတခါအံၤန့ဉ်, ကိးဘဉ်လီတဲစိနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တကွ၊်.

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. Hennepin Health 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: Hennepin Health 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:** Hennepin Health Member Services at hennepinhealth@hennepin.us, or call Hennepin Health Member Services at 612-596-1036 (voice) or 1-800-647-0550 (toll-free), or your preferred relay service.

Language Assistance Services: Hennepin Health 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:** Hennepin Health Member Services at hennepinhealth@hennepin.us, or call Hennepin Health Member Services at 612-596-1036 (voice) or 1-800-647-0550 (toll-free), or your preferred relay service.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Hennepin Health. 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 a 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 period. 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 administration actions.

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

Hennepin Health Complaint Notice

You have the right to file a complaint with Hennepin Health 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:

Hennepin Health
Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, MN 55415
Toll Free: 1-800-647-0550 (voice)
1-800-627-3529 (MN Relay)
612-632-8815 (Fax)
hennepinhealth@hennepin.us (Email)

American Indians: American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require approval or impose any condition 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.

HENNEPIN HEALTH SPECIAL NEEDS BASIC CARE ENROLLMENT FORM

Last name	First name	MI	Birth date	Gender ❑ M ❑ F

County you live in	Social Security number (optional)	Phone number ( )

Street address (where you live)	City	State	Zip code:

Mailing address (If different from where you live)	City	State	Zip code:

Email address (optional)

Medical Assistance ID number	Case number	Are you pregnant? ❑ YES ❑ NO

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) ❑ American Sign Language (08) ❑ Arabic (09)
❑ Serbo-Croatian/Bosnian (11) ❑ Oromo (12) ❑ (98) Other, explain _____

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

Do you have Medicare coverage? ❑ YES ❑ NO If Yes, complete the information below

Medicare number:
Hospital (Part A) Begin Date: Medical (Part B) Begin Date:

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.

Some individuals may have other medical coverage, including other private insurance.

Do you have other medical coverage? ❑ YES ❑ NO

If **Yes**, insurance company name: _____

Policyholder's name: _____

Policy number: _____

Is this insurance through an employer? ❑ YES ❑ NO

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.

Primary care clinic you are choosing	Primary care clinic (PCC) number

Please read and sign the back of this form
Under Hennepin Health, I understand that:

Hennepin Health will be providing my health care covered by Medical Assistance (Medicaid).
Once I am a member of **Hennepin Health**, I have the right to appeal any services that are being denied, reduced, or stopped, or if **Hennepin Health** is denying payment for services.
I will be notified of the date my coverage will start.
On the date **Hennepin Health** coverage begins, I must get my health care from **Hennepin Health** doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get **Hennepin Health** approval to see other providers in some circumstances.
I will read the Member Handbook I get from **Hennepin Health**. It will have the rules I must follow and more information about the services my plan covers. Services contained in **Hennepin Health's** Member Handbook will be covered.
Some services require authorization from **Hennepin Health**. Without authorization, **Hennepin Health** will not pay for these services.
My **Hennepin Health** benefits **cannot** be canceled because I get sick or use health care services.
I can choose to leave **Hennepin Health** and change back to Medical Assistance (Medicaid) fee-for-service, effective the following month. I understand that I will be enrolled in **Hennepin Health** through the last day of the month.
My health care services will be coordinated through **Hennepin Health**. I may have to choose a primary care clinic.

To be enrolled and stay enrolled in **Hennepin Health**, 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 **Hennepin Health**

If this changes, I will notify my county worker and **Hennepin Health** 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 Hennepin Health.

If I am on Medical Assistance (Medicaid) for Employed Persons with Disabilities (MA-EPD), I must continue to pay my MA-EPD premium to remain eligible for Medical Assistance (Medicaid).

By enrolling in Hennepin Health, 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 **Hennepin Health**.

The information on this enrollment form is correct to the best of my knowledge.

I understand that my signature (or the signature of 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 Hennepin Health.

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		

Instructions

For filling out the **Hennepin Health** Enrollment Form

Please fill in the following information on your enrollment form.

Last name:	Write your last name.
First name:	Write your first name.
MI:	Write your middle initial.
Date of birth:	Write the month, day, and year you were born.
Gender:	Check the box indicating if you are male or female.
County you live in:	Write the county where you live.
Social Security number:	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.
Phone number:	Write the telephone number where you can be reached during the day.
Street address (where you live):	Write the permanent street address where you live (no P.O. boxes).
City:	Write the city for the permanent street address where you live.
State:	Write the state for the permanent street address where you live.
Zip code:	Write the zip code for the permanent street address where you live.
Mailing address (if different from where you live):	Write the street address or P.O. box where you receive your mail if different from where you live.
City:	Write the city of the address where you receive your mail if different from where you live.
State:	Write the state of the address where you receive your mail if different from where you live.
Zip code:	Write the zip code of the address where you receive your mail if different from where you live.
Email address:	Write the email address where you can be contacted. You do not have to complete this field if you choose not to.
Medical Assistance ID number:	Write in the number as it appears on your Minnesota Health Care Programs card.
Case number:	Write your Medical Assistance case number.
Are you pregnant?	If you are pregnant, check "Yes." If you are not pregnant, check "No."
Do you need an interpreter?	Check "Yes" or "No." If you answer "Yes," circle the code of the language needed on the list.

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."
Do you have Medicare coverage?	Check "Yes" or "No." If you answer "Yes":
Medicare claim number:	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).
Hospital (Part A) effective date:	Write in the effective date for Hospital (Part A) as it appears on your card.
Medical (Part B) effective date:	Write in the effective date for Medical (Part B) as it appears on your card.
Do you have End-Stage Renal Disease (ESRD)?	End Stage Renal Disease means you have kidney failure. If you have End Stage Renal Disease, check: "Yes" or "No."
If Yes, date dialysis started:	If you answer "Yes," add the date that you started dialysis.
Do you have other medical coverage?	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."
Name of your insurance company:	If you have other medical coverage, write in the name of the insurance company.
Policyholder's name:	Write the name of the policyholder.
Policy number:	Write in the policy number.
Is this insurance through an employer?	If this insurance is through an employer, check "Yes." If it is not through an employer, check "No."
Primary care clinic you are choosing:	Go to the health plan's Provider Directory in your information packet. Write the name of the primary care provider, clinic or health center that you are choosing.
Primary care clinic (PCC) number:	Go to the health plan's Provider Directory in your information packet. Write the number of the primary care provider, clinic or health center that you are choosing.

Page 3 should be signed and filled out by you or your authorized representative.

When the form is completed, mail or fax to Hennepin Health. Our address and fax number is:

Hennepin Health
400 South Fourth Street, Suite 201
Minneapolis, MN 55415
Fax: 612-632-8618