Hennepin Health Special Needs BasicCare (SNBC) Enrollment Form

Hennepin Health Special Needs BasicCare (SNBC) Enrollment and Member Services Telephone Numbers
612-596-1036 (800-647-0550). TTY for the hearing impaired at TTY 711 (800-627-3529). 8 a.m. - 4:30 p.m., Monday - Friday. The call is free.

You can speak to someone about getting this information for free in other languages. Call Hennepin Health Toll Free 1-800-647-0550. TTY users should call 1-800-627-3529. The call is free.

Return the completed form, pages 2 to 4, to:

Hennepin Health
300 S 6th St. MC 604
Minneapolis, MN 55487-0604

Fax: 612-632-8618

Hennepin Health
your community health plan

SPECIAL NEEDS BASICCARE ENROLLMENT FORM

Last name	First name	MI (optional)	Birth date (__/__/____) MM/DD/YYYY	Gender ❑ M ❑ F
County you live in	Phone number (___) ___-_____	[Optional: Another 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 (PMI)	Case number			

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) ❑ Amharic (09)

❑ Arabic (10) ❑ Oromo (12) ❑ Burmese (14) ❑ Cantonese (15) ❑ French (16) ❑ Korean (20)

❑ Karen (21) ❑ Other (98) explain _____

Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT)? ❑ YES ❑ NO

[Optional] Do you live in a long-term care facility? ❑ YES ❑ NO
If Yes, fill in the information below:
Name of the facility: Phone number: (___) ___- ____

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 *other* medical coverage or private insurance?

❑ YES ❑ NO

If Yes, insurance company name: _____

Policyholder's name: _____Group number:_____

Policy/ID number: _____

Is this insurance through an employer? ❑ YES ❑ NO

YOU ARE CHOOSING HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Enrolling in a SNBC health plan is voluntary. You can request to change to Medical Assistance fee-for-service and the change will occur for the next available month.

Primary care clinic you are choosing	Primary care clinic (PCC) provider ID number found in the Provider and Pharmacy Directory

Please read and sign this form

Under *Hennepin Health Special Needs BasicCare (SNBC),* I understand that:

Hennepin Health Special Needs BasicCare (SNBC) will be providing my health care covered by Medical Assistance
I have the right to appeal if services are denied, reduced, or stopped, or if **Hennepin Health Special Needs BasicCare (SNBC)** denies paying for services.
I will be notified through a mailed letter by the Department of Human Services (DHS) in advance of when my coverage will start with **Hennepin Health Special Needs BasicCare (SNBC)**.
When my **Hennepin Health Special Needs BasicCare (SNBC)** coverage begins, I must use **Hennepin Health Special Needs BasicCare (SNBC)** doctors and other providers. I can only see other doctors in emergencies urgently needed care, open access services, out-of-area dialysis, or if I get **Hennepin Health Special Needs BasicCare (SNBC)** approval to see other providers..
I will read the Member Handbook from **Hennepin Health Special Needs BasicCare (SNBC)**. It will tell me the rules I need to follow and explain the services my plan covers. Services contained in **Hennepin Health Special Needs BasicCare (SNBC)'s** Member Handbook will be covered.
Some services require authorization from **Hennepin Health Special Needs BasicCare (SNBC)**. Without authorization, **Hennepin Health Special Needs BasicCare (SNBC)** will not pay for these services.
My **Hennepin Health Special Needs BasicCare (SNBC)** benefits **cannot** be canceled if I get sick or use health care services. This means you will keep your coverage even if you need to use it often.
I can choose to leave **Hennepin Health Special Needs BasicCare (SNBC)** and change back to Medical Assistance fee-for-service. The health plan change will start based on when my request is received at DHS. I will stay enrolled in **Hennepin Health Special Needs BasicCare (SNBC)** through the last day of the month.

My health care services will be coordinated through **Hennepin Health Special Needs BasicCare (SNBC)**.

To be enrolled in **Hennepin Health Special Needs BasicCare (SNBC)**, I must:

- Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT)
- Be at least 18 years old and under 65 years old
- Be eligible for Medical Assistance without a medical spenddown
- Either have no Medicare, **OR** have **both** Medicare Parts A **and** B
- Live in a county serviced by **Hennepin Health Special Needs BasicCare (SNBC)**

If anything changes, I will notify my county worker and **Hennepin Health Special Needs BasicCare (SNBC).**

If I am enrolled in SNBC and later get a medical spenddown that I **do not pay it to DHS**, I will be disenrolled from Hennepin Health Special Needs BasicCare (SNBC).

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

By enrolling in Hennepin Health Special Needs BasicCare (SNBC), I authorize:

The sharing of information about my Medical Assistance eligibility and the information on this form with the state, its representatives, the county where I live, and **Hennepin Health Special Needs BasicCare (SNBC)**.

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 Hennepin Health Special Needs BasicCare (SNBC).

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 code:		

You or your authorized representative must sign above.

When the form is completed, mail or fax it to Hennepin Health Special Needs BasicCare (SNBC). Our address and fax number is located on page 1 of this document.

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.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

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

သတိ။ ဤစာရက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း 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.

ပ်သူဉ်ပ်သးဘဉ်တက့်၊ ဖဲနမ့်၊လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လီတဲစိနီ်၊ဂံ်လၢထးအံၤန့ဉ်တက့်၊

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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 (afcelinta) 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

You have the right to file a complaint if you believe you were treated in a discriminatory way by Hennepin Health. You can file a complaint and ask for help filing a complaint by mail, phone, fax, or email at:

Hennepin Health
300 South Sixth Street MC 604
Minneapolis MN 55487-0604
Toll-free: 1-800-647-0550 (voice)
TTY: 1-800-627-3529 (MN Relay)
Fax: 612-632-8815
Email: hennepinhealth@hennepin.us

or in person at:

Hennepin Health
525 Portland Avenue South
Minneapolis

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 (toll-free 1-800-647-0550) 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 (toll-free 1-800-647-0550) 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 also contact any of the following 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
- religion (in some cases)

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

Office of Civil Rights, U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240 Chicago, IL 60601
Customer Response Center: 800-368-1019, TTY 800-537-7697
Email: ocrmail@hhs.gov

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
540 Fairview Avenue North, Suite 201, St. Paul, MN 55104
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
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

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. 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 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 administration 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

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 go to your primary care provider prior to the referral.