

SOUTH COUNTRY

**HEALTH ALLIANCE**

*Bringing Wellness Home*

110 West Fremont Street  
Owatonna, MN 55060

Fax: 507-431-6328

*AbilityCare* (HMO SNP)

## Enrollment Form Special Needs Basic Care - SNP

South Country Health Alliance Member Services/Enrollment

1-866-567-7242 (Toll Free)

TTY for the hearing impaired at 711

8:00 a.m. – 8:00 p.m., seven days a week

**Return the completed form to:**

**AbilityCare**

**South Country Health Alliance**

**110 West Fremont Street, Owatonna, MN 55060**

**Fax: 507-431-6328**

AbilityCare is a Coordinated Care plan with a Medicare Advantage contract and a contract with the Minnesota Medicaid program.

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການເປາຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງໂທຕາມເລກໂທທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

This information is available in other forms to people with disabilities by calling **1-866-567-7242** (toll free) or **711**, (TTY), or through the Minnesota Relay at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

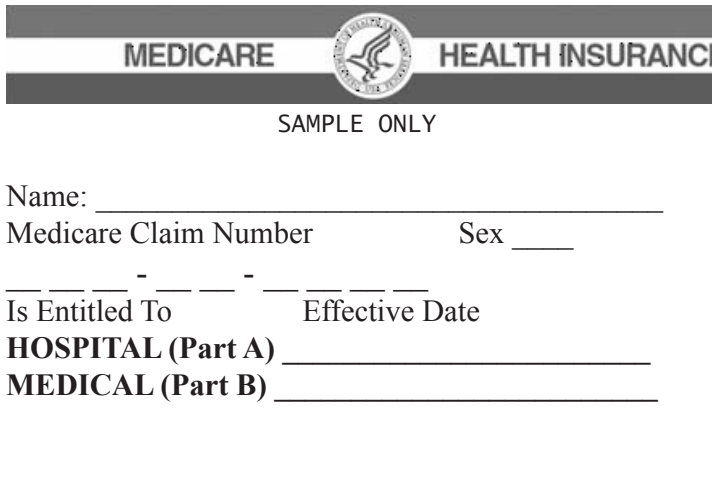
**American Indians** can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the 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.

Member Name: \_\_\_\_\_ Medical Assistance # \_\_\_\_\_

Office Use Only:  
 Date: \_\_\_\_\_  
 Name of Authorized Sales Person \_\_\_\_\_  
 Effective Date of Enrollment \_\_\_\_\_  
 LIS Co-Pay Level \_\_\_\_\_  
 LIS Co-Pay Eff Date \_\_\_\_\_  
 Approved By \_\_\_\_\_

## AbilityCare (HMO SNP) – Special Needs Basic Care – SNP Enrollment Form

To Enroll in AbilityCare, Please Provide the Following Information:

1	Last Name:	First Name:	M.I.	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	<b>Mailing Address</b> (only if different from your Permanent Residence Address) Full Name (if different from applicant) _____ Street Address: _____ City: _____ State: _____ Zip Code: _____				
5	<b>Emergency contact:</b> _____ <b>Phone Number:</b> _____ <b>Relationship to You:</b> _____				
6	<b>E-mail Address:</b> _____				
<b>Please Provide Your Medicare Insurance Information</b>					
7	Please take out your Medicare card to complete this section. <ul style="list-style-type: none"> <li>Please fill in these blanks so they match your red, white, and blue Medicare card.</li> </ul> - OR - <ul style="list-style-type: none"> <li>Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.</li> </ul> You must have Medicare Part A and Part B to join a Medicare Advantage plan.		 <p style="text-align: center;">SAMPLE ONLY</p> Name: _____ Medicare Claim Number _____ Sex _____ _____ - _____ - _____ Is Entitled To _____ Effective Date _____ <b>HOSPITAL (Part A)</b> _____ <b>MEDICAL (Part B)</b> _____		
8	Please provide your Medical Assistance ID number (it is on your Minnesota Health Care Programs card): _____				
9	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 Facility: _____ Phone number of Facility: _____				

10	Primary care clinic/Care system/Primary care provider you are choosing:	Primary care clinic/Care system/Primary care provider ID number found in <b><i>Provider Directory/Primary Clinic Network Listing</i></b> :				
11	Do you need an interpreter? Yes No If "Yes," circle correct language					
01 Spanish 07 Somali		02 Hmong 08 ASL American Sign Language	03 Vietnamese 10 Arabic	04 Khmer (Cambodian) 11 Serbo-Croatian/Bosnian	05 Lao 12 Oromo	06 Russian 98 Other _____
12	<b>Please read and answer these important questions:</b>					
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? Yes No						
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, <b>please attach a note or records</b> 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:						
Name of other coverage: _____						
ID# for this coverage: _____						
Group # for this coverage: _____						
5. Do you or your spouse have health insurance, including through a previous or current employer?						
Yes No						
If "Yes," employer/insurer name: _____						
Policy holder's name: _____						
Policy #: _____						



## 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.

### Please read and sign on page 5

#### 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 at the time of enrollment
  - 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.

- I can choose to leave AbilityCare at any time. 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 the Prepaid Medical Assistance Program (PMAP) 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 when I get it 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.**

Member Name: \_\_\_\_\_ Medical Assistance # \_\_\_\_\_

- 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.
- By enrolling in AbilityCare, I authorize the State to give information about my Medicare and Medical Assistance status and the information on this form to its representatives, the county where I live now, and to South Country Health Alliance.
- 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.

\_\_\_\_\_  
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

## Instructions

### For filling out the AbilityCare Enrollment Form

Please print as neatly as possible.

Please fill in the following information by numbered line on your 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.
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: Full Name:	Write in the address where you receive your mail, if different from your permanent street address. Include street address, city, state, and zip code (no P.O. boxes).
5	<b>Emergency contact</b>	Name and phone number of contact and their relationship to you.
6	<b>E-mail Address</b>	If you have an email address, add it.
7	Medicare Number:  Effective Date Hospital (Part A):  Effective Date Medical (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.
8	Medical Assistance ID Number:	Write in your Medical Assistance number.
9	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, address, and phone number. If you do not, check "No."
10	Primary care clinic/Care system/ Primary care provider:  Primary care clinic/Care system/ Primary care provider #:	Go to the health plan's <b>Provider Directory/Primary Care Network Listing</b> in your information packet. Write in the primary care clinic/care system/medical home that you choose.  Write the code of the primary care clinic/care system/medical home that you choose, located in the <b>Provider Directory/Primary Care Network Listing</b> .
11	Do you need an interpreter?	Check "Yes" or "No." If you answer "Yes," circle the code of the language needed on the list.
12	1. Medical Spenddown 2. Certified Disability 3. End Stage Renal Disease  4. Other prescription drug Coverage:  5. Other health insurance:	Check "Yes" or "No." Check "Yes" or "No." Check "Yes" or "No."  If you answered "Yes" to this question, please fill out the name of the other coverage, the ID number, and Group number.  If you answered "Yes" to this question, please fill out the employer/insurer name, policy holder's name, and policy number.

Page 5 should be signed and filled out by you or your authorized representative.

When the form is completed, mail or fax it to AbilityCare. Our address and fax number are on the cover.