2024

South Country Health Alliance

AbilityCare (HMO D-SNP) Enrollment Form

South Country Health Alliance Member Services Telephone Numbers

1-866-567-7242 ◆ TTY for the hearing impaired at 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, page numbers 1 to 5, to:

South Country Health Alliance
6380 W Frontage Rd
Medford, MN 55049

Fax: 507-431-6328

AbilityCare (HMO D-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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South Country HEALTH ALLIANCE

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.

ပာ်သူဉ်ပာ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤန့ဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤန့ဉ်တက့ၢ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-567-7242. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-567-7242. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-567-7242。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-567-7242。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-567-7242. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-567-7242. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-567-7242 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-567-7242. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-567-7242 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-567-7242. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-567-7242. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-567-7242 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-567-7242. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-567-7242. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-567-7242. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-567-7242. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-567-7242 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Civil Rights Notice

Discrimination is against the law. South Country Health Alliance (South Country) 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 discrimination complaint if you believe you were treated in a discriminatory way by South Country. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
South Country Health Alliance
6380 West Frontage Road, Medford, MN 55049
Toll Free: 866-567-7242 TTY: 800-627-3529 or 711 Fax: 507-444-7774
Email: grievances-appeals@mnscha.org

Auxiliary Aids and Services: South Country 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** Member Services at members@mnscha.org or call 866-567-7242, TTY 800-627-3529 or 711.

Language Assistance Services: South Country 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** Member Services at members@mnscha.org or call 866-567-7242, TTY 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 South Country. 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 for 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 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 the 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 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

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.

Member Name: _____ MHCP Member Number: _____

2024 AbilityCare (HMO D-SNP) Enrollment Request Form

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

To join AbilityCare, you must have **Medicare Part A**, **Medicare Part B**, and **Medical Assistance (Medicaid) without a medical spenddown**, **and** be at least 18 and under age 65, have a certified disability through the Social Security Administration or the State Medical Review Team, **and** live in AbilityCare's service area.

Section 1. Tell us about yourself:

1	**Name: (first, middle, last)**			
2	**Date of birth: (M M / D D / Y Y Y Y)** M M D D Y Y Y Y		**Sex:** ☐ **Female** ☐ **Male**	
3	**Phone number:** (_____) _____ - _____		**Another phone number (optional):** (_____) _____ - _____	
4	**Address where you live (P.O. Box is not allowed):**			
	City:	**State:**	**ZIP code:**	**County:**
5	**Address where you get mail (if different from where you live):**			
	City:	**State:**	**ZIP code:**	**County:**
6	**Do you live in a long-term care facility?** ☐ **Yes** ☐ **No** If Yes, fill in the information below: **Name of the facility:** **Phone number:** (_____) _____ - _____			
7	**Do you need an interpreter?** ☐ **Yes** ☐ **No** If Yes, check the language below: ☐ 01 Spanish ☐ 02 Hmong ☐ 03 Vietnamese ☐ 04 Khmer (Cambodian) ☐ 05 Lao ☐ 06 Russian ☐ 07 Somali ☐ 08 ASL (American Sign Language) ☐ 09 Amharic ☐ 10 Arabic ☐ 12 Oromo ☐ 14 Burmese ☐ 15 Cantonese ☐ 16 French ☐ 20 Korean ☐ 21 Karen ☐ 98 Other _____			
8	**Authorized Representative**:		**Authorized Representative phone number:** (_____) _____ - _____	

Member Name: _____ MHCP Member Number: _____

Section 2. Tell us more about yourself:

You are not required to answer questions or give any information in this section. It's your choice to share this information with us. We can't deny you coverage if you don't answer them.

9	**Do you want us to send you information in a language other than English?** ☐ **Yes** ☐ **No** If Yes, write language: _____
10	**Do you want us to send you information in an accessible format?** ☐ **Yes** ☐ **No** If Yes, check format below. ☐ Braille ☐ Large print ☐ Audio Please contact AbilityCare at 1-866-567-7242 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 a.m. - 8 p.m. (October – March) ; Monday - Friday, 8 a.m. - 8 p.m. (April - September). TTY users can call 1-800-627-3529 or 711.
11	**Are you Hispanic, Latino/a, or Spanish origin?** Select all that apply. ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, another Hispanic, Latino/a or Spanish origin ☐ I choose not to answer
12	**What's your race?** Select all that apply. ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ I chose not to answer
13	**Do you want to get information by email?** ☐ **Yes** ☐ **No** If Yes, provide your email address below. **Email:** _____
14	**Do you work?** ☐ **Yes** ☐ **No** **Does your spouse or domestic partner work?** ☐ **Yes** ☐ **No** ☐ Does not apply
15	**Name of the primary care clinic/care system you are choosing:**

Section 3. Tell us about your Medicare and Medical Assistance (Medicaid) coverage:

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) Member Number as it appears on the front of your card. This is also known as your Medical Assistance Member Number.

16	**Medicare Number:** _____	**MHCP Member Number:** _____

Member Name: _____ MHCP Member Number: _____

Section 4. Tell us about your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

17	**Do you have other health coverage?** ☐ **Yes** ☐ **No**	If Yes, fill in the information below:
18	**Name of your plan (and employer, if applicable):**	**Group number:**
		ID number:

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join AbilityCare. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

Section 5. Tell us about your enrollment eligibility.

Please read the following statements carefully and check the box if the statement applies to you. **Check all that apply**. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am applying during the Medicare Advantage plan annual enrollment period from October 15 through December 7 and want my enrollment effective January 1.

☐ I am new to Medicare.

☐ I have both Medicare and Medical Assistance (Medicaid) (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I recently had a change in my Medical Assistance (Medicaid) (newly got Medicaid or had a change in level of Medicaid assistance) on (date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (date) _____.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on (date) _____.

☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (date) _____.

☐ I am leaving employer or union coverage on (date) _____.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (date) _____.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (date) _____.

☐ I recently was released from incarceration. I was released on (date) _____.

Member Name: _____ MHCP Member Number: _____

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (date) _____.

☐ I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact AbilityCare at 1-866-567-7242 (TTY users should call 1-800-627-3529 or 711) to find out if you're eligible to enroll. We are open 7 days a week, 8 a.m. - 8 p.m. (October - March) ; Monday - Friday, 8 a.m. - 8 p.m.(April - September).

Information and Acknowledgement Statements

- My response to this form is voluntary. I understand that my enrollment in AbilityCare may be affected if I don't respond.
- I must keep Medicare Part A and Part B and Medical Assistance (Medicaid) to stay in AbilityCare.
- By joining AbilityCare, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize collection of this information (refer to the Privacy Act Statement below).
- On the date AbilityCare coverage begins, I must get my medical and prescription drug benefits from AbilityCare.
- Benefits and services AbilityCare provides and contained in my *Member Handbook* are covered. Neither Medicare nor AbilityCare will pay for benefits or services that are not covered.
- I understand that AbilityCare doesn't usually cover people while they're out of the country except under limited circumstances.
- If I move, I need to tell my county worker.
- I can choose to leave AbilityCare at certain times of the year. 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 (Medicaid) fee-for-service unless I am otherwise required to enroll in Families and Children.
- If I get a medical spenddown while enrolled in AbilityCare and do not pay it to the State, I will be disenrolled from AbilityCare.
- The information on this enrollment form is correct to the best of my knowledge. I understand that I will be disenrolled from AbilityCare if I intentionally give false information on this form.
- My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that they are authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Medical Assistance (Medicaid).

Member Name: _____ MHCP Member Number: _____

Please read the information on pages 3 and 4 and sign below.

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) Telephone Number

When the form is complete, mail or fax page numbers 1 to 5 to South Country Health Alliance. Our address and fax number are on the cover.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

<Office Use Only:
Date: _____
Name of Authorized Sales Person: _____>
[Effective Date of Enrollment _____
Election Code _____
LIS Copay Level _____
LIS Copay Effective Date _____
Approved by _____]

Reset Form