2024

SingleCare/SharedCare (SNBC MA37) 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.
8 a.m. to 5 p.m., Monday through Friday.
The call is free.

You can speak to someone about getting this information for free in other languages. Call 1-866-567-7242. TTY users should call 1-800-627-3529 or 711, 8 a.m. to 5 p.m., Monday through Friday. The call is free.

Return the completed form, pages 1 to 3, to:

South Country Health Alliance
6380 West Frontage Road
Medford, MN 55049

Fax: 507-431-6328

6784

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 တီလံာ်မီတခါအံၤန့ၣ်,ကိးဘဉ် လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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 (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. 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.

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

Office Use Only
Date:____________________
Name of Authorized Sales Person ____________
Effective Date of Enrollment ____________
LIS Copay Level______ LIS Copay Eff Date ________
Tracking #____________________
Approved By____________________

SINGLECARE/SHAREDCARE ENROLLMENT FORM

Last name	First name	MI (optional)	Birth date (____/____/_____) MM / DD / YYYY	Gender ❑ M ❑ F
County you live in	Phone number (____) ____-________	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

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

Remember, joining SNBC is voluntary. You can always request to change back to Medical Assistance fee-for-service effective the 1st of the next month.

Please read and sign the back of this form

Under South Country Health Alliance (South Country) SingleCare/SharedCare, I understand that:

South Country SingleCare/SharedCare will be providing my health care covered by Medical Assistance
Once I am a member of **South Country SingleCare/SharedCare**, I have the right to appeal any services that are being denied, reduced, or stopped, or if **South Country SingleCare/SharedCare** is denying payment for services.
I will be notified of the date my coverage will start.
On the date **South Country SingleCare/SharedCare** coverage begins, I must get my health care from **South Country SingleCare/SharedCare** doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get **South Country SingleCare/SharedCare** approval to see other providers in some circumstances.
I will read the Member Handbook from **South Country SingleCare/SharedCare**. It will have the rules I must follow and more information about the services my plan covers. Services contained in **South Country Health Alliance SingleCare/SharedCare's** Member Handbook will be covered.
Some services require authorization from **South Country SingleCare/SharedCare**. Without authorization, **South Country SingleCare/SharedCare** will not pay for these services.
My **South Country SingleCare/SharedCare** benefits cannot be canceled because I get sick or use health care services.
I can choose to leave **South Country SingleCare/SharedCare** and change back to Medical Assistance fee-for-service. The effective date depends upon the date your request is received. I understand that I will be enrolled in **South Country SingleCare/SharedCare** through the last day of the month.
My health care services will be coordinated through **South Country SingleCare/SharedCare**.
To be enrolled and stay enrolled in **South Country SingleCare/SharedCare**, 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 health care through Medical Assistance without a medical spenddown ● Either have no Medicare, **OR** have both Medicare Parts A **and** B ● Live in a county serviced by **South Country SingleCare/SharedCare** If this changes, I will notify my county worker and **South Country SingleCare/SharedCare** so my information can be updated.

If I get a medical spenddown while enrolled in SNBC and **do not pay it to DHS**, I will be disenrolled from South Country SingleCare/SharedCare.
If I am on Medical Assistance for Employed Persons with Disabilities (MA-EPD), I must continue to pay my MA-EPD premium to remain eligible for Medical Assistance.

By enrolling in South Country SingleCare/SharedCare, I authorize:

The sharing of information about my Medical Assistance eligibility status and the information on this form among the state, its representatives, the county where I live, and **South Country SingleCare/SharedCare**.
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 South Country Health Alliance (South Country) SingleCare/SharedCare.

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:		

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

When the form is completed, mail or fax pages 1 to 3 to South Country SingleCare/SharedCare.
Our address and fax number is on the cover.