Exemption Request Form
Granite Advantage Health Care Program

Use this form to request an exemption from the Granite Advantage Community Engagement requirements. **DETAILED INSTRUCTIONS ARE ENCLOSED.** If a licensed medical professional must certify the exemption, ask them to complete the Section III. Please note you can find your Medicaid ID Number (MID) in the lower left hand front corner of your blue Medicaid card that has **State of New Hampshire** on the front. If you are unable to locate your MID number, you may enter your birth date instead.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last ____________________________ First ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID#: ______________ Date of Birth ____________ ____________</td>
<td></td>
</tr>
</tbody>
</table>

### Section I. Self-attested exemptions and exemptions requiring beneficiary ACTION

- [ ] Participation in State Certified Drug Court Program
  - Attach a copy of the legal documentation
- [ ] Parent/Caretaker of Dependent Child Under 6
  - Enter the child's DOB in the box at the bottom of the page
- [ ] Pregnant or Within 60 Days Post-partum
  - Due Date: ______________

By filling in the circle for an exemption in Section I or II below and signing this form, I attest under penalty of unsworn falsification pursuant to RSA 641:3 that the information provided to the department in support of this request is true to the best of my knowledge and belief.

| Benefitary Signature ____________________________ Date ____________________________ |

### Section II. Exemptions requiring CERTIFICATION BY A LICENSED MEDICAL PROFESSIONAL

- [ ] Disability
  - Licensed Medical Professional
- [ ] Caretaker Residing With Immediate Family Member with Disability
  - Licensed Medical Professional
- [ ] Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient Treatment
  - Licensed Medical Professional
- [ ] Inpatient Hospitalization
  - Licensed Medical Professional
- [ ] Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness
  - Licensed Medical Professional
- [ ] Parent/Caretaker of Developmentally Disabled Child
  - Licensed Medical Professional
- [ ] Parent/Caretaker of Family Member Requiring Care
  - Licensed Medical Professional

Exemption Request Form- Granite Advantage Health Care Program
For the **Inpatient Hospitalization** exemption, enter the hospital admitted date below:

Admitted Date: ______ ______ ______

For any **Parent or Caretaker** exemption, enter the information for the person being cared for below:

Full Name: ________________________________________  ________________________________________  

Last    First

Date of Birth (MMDDYYYY): ______ ______ ______

**Section III. Licensed Medical Professional Section**

As a licensed medical professional caring for this beneficiary, I hereby certify (based on the description of the exemptions provided in the instructions to this form) that the beneficiary meets the qualifications for the exemption(s) requested in Section II.

This certification is valid through (may not exceed one year): ______ ______ ______

Provider Name (Please Print):  

NPI #: ________________________________________

Date:  

Contact #: ( )

Provider Signature: ____________________________________________________________
Instructions For Completing the Form

Beneficiary Instructions:

1. Complete your beneficiary information and sign the top section of the form. Please note you can find your Medicaid ID Number (MID) in the lower left hand front corner of your blue Medicaid card that has State of New Hampshire on the front. If you are unable to locate your MID number, you may enter your birth date instead.
2. After reviewing the description of the various exemptions below, fill in the circle in the far-left column of the row which applies to the exemption(s) that you are requesting.
3. If you are requesting an exemption as a parent or a caretaker, enter the name and DOB of the person being cared for.
4. If the exemption type requires certification by a licensed medical professional, request that the licensed medical professional complete Section III of the form.
5. You MUST return this form to the Department of Health and Human Services either by mail at the address on top of the first page, by fax to 603-271-5623, by submitting the form to your NH EASY account, or bringing the form to your local district office. You may submit to NH EASY or bring to your local district office the exemption form that requires certification by a licensed medical professional only if the licensed medical professional has certified that you meet the qualifications for an exemption.

Licensed Medical Professional Instructions:

1. Review the Description of Exemptions below and the exemption(s) that the beneficiary has selected in Section II of the form for accuracy.
2. Enter the certification end-date for the exemption if known.
3. Fill in your provider information and sign the bottom section of the form.
4. If you are submitting this form on behalf of the beneficiary, please send it to the return address on the front page, or fax it to 603-271-5623.

Description of Exemptions

<table>
<thead>
<tr>
<th>Description of Exemptions</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in State Certified Drug Court Program</td>
<td>The beneficiary is participating in a state certified drug court program that has been certified by the administrative office of the superior court. This requires a copy of the legal documentation requiring the beneficiary to participate in the state drug court program.</td>
</tr>
<tr>
<td>Parent/Caretaker of Dependent Child Under 6</td>
<td>The beneficiary is a custodial parent or caretaker of a dependent child under 6 years of age. Enter the name and DOB of the child.</td>
</tr>
<tr>
<td>Pregnant or Within 60 Days Post-partum</td>
<td>The beneficiary is pregnant or within 60 days post-partum. Enter the due date.</td>
</tr>
<tr>
<td>Disability</td>
<td>The beneficiary has a disability as defined in He-W 837.01(h) and is unable to comply with the community engagement requirement due to disability-related reasons. This exemption requires that a licensed medical professional certify the disability.</td>
</tr>
<tr>
<td>Caretaker Residing With Immediate Family Member with Disability</td>
<td>The beneficiary resides with an immediate family member who has a disability as defined in He-W 837.01(h) and is unable to meet the community engagement requirement for reasons related to the disability of that family member. This exemption requires that a licensed medical professional certify the family member’s disability.</td>
</tr>
<tr>
<td>Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient SUD Treatment</td>
<td>The beneficiary is unable to participate in the requirements due to illness, incapacity, or treatment. This exemption includes the beneficiary’s participation in inpatient and residential outpatient substance use disorder treatment or in intensive outpatient substance use disorder services that is consistent with ASAM Levels 2.1 and above. This exemption requires a licensed medical professional certify the illness, incapacity or treatment including inpatient or residential outpatient treatment.</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>The beneficiary experiences a hospitalization. This exemption requires copies of discharge summaries, or financial or billing information, documenting the hospitalization or dates of stay.</td>
</tr>
<tr>
<td>Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness</td>
<td>The beneficiary resides with an immediate family member who experiences a hospitalization or serious illness. This exemption requires copies of discharge summaries, or financial or billing information, documenting the hospitalization or serious illness or dates of stay.</td>
</tr>
<tr>
<td>Parent/Caretaker of Developmentally Disabled Child</td>
<td>The beneficiary is a custodial parent or caretaker of a child with developmental disabilities who is residing with the parent or caretaker. This exemption requires that a licensed medical professional certify the child’s developmental disability.</td>
</tr>
<tr>
<td>Parent/Caretaker of Family Member Requiring Care</td>
<td>The beneficiary is a custodial parent or caretaker who is required to be in the home to care for another relative who resides in the same household due to that individual’s illness, incapacity or disability and there is no other household member to provide the care.</td>
</tr>
</tbody>
</table>