



March 29, 2019

JANE DOE
 MAIN ST
 CONCORD NH 03301

 Aviso importante acerca de sus beneficios. Por favor llame a la Oficina del Distrito si tiene alguna duda o pregunta. También puede solicitar servicios gratuitos de un intérprete.

IMPORTANT! Please read this entire letter about the Granite Advantage Health Care Program Community Engagement requirements. If you need help with reading or understanding this letter, please contact the Department of Health and Human Services Customer Service Line at **1-844-275-3447 (1-844-ASK DHHS.)**

Recently DHHS sent you a letter explaining the Community Engagement requirement under the Granite Advantage Health Program and indicating your participation status as Mandatory. As you may be aware, people covered by Medicaid through Granite Advantage typically must complete 100 hours of Community Engagement activities each month to maintain medical coverage unless they are exempted.

You told us previously that you are Medically Frail. To be exempt from the Community Engagement requirement due to medical frailty, you need to provide documentation from a licensed medical professional of your frailty. **This letter is a friendly reminder that we have not yet received your medical frailty form signed by your licensed medical provider. Therefore, your Participation Status remains as Mandatory unless we receive your signed Medical Frailty form.** We encourage you to complete the enclosed authorization form and have a licensed medical professional sign the certification of your medical frailty.

Please note we need your completed Medical Frailty form by June 01, 2019 in order to exempt you from the Community Engagement requirement. You may send us your form after June 01, 2019 as well, however your status will be mandatory until we get the Medical Frailty form. If you do not meet the hours requirement and you are not exempt, your Medicaid eligibility could be suspended after two consecutive months of non-compliance.

COMMUNITY ENGAGEMENT STATUS

| Participation Status | Participation Start Date | Monthly Hours | | |
|----------------------|--------------------------|---------------|---------|--------|
| | | Required | Current | Needed |
| Mandatory | 06/01/2019 | 100 | 0 | 100 |

If your Participation Status remains mandatory, you must complete 100 hours of Community Engagement activities per month. You can report hours throughout the month, but you must report all hours by the 7th day of the next month. For example, if your Participation Start Date is June 01, 2019, you need to report 100 hours of activities completed between June 01, 2019 and June 30, 2019 by July 07, 2019.

How to find out more about Community Engagement

To learn more about Community Engagement, visit <https://nheasy.nh.gov/#/granite-advantage> or call DHHS Customer Service at 1-844-275-3447 (1-844-ASK DHHS).

The best way to manage your Community Engagement is through NH EASY

To create your account, go to NH EASY by entering the following URL into your internet browser: <https://nheasy.nh.gov>. Here is your **NH EASY PIN Q9842**. Keep this in a safe place where no one else can see it.

Access your Community Engagement details 24 hours a day, 7 days a week by calling Customer Service and selecting the Granite Advantage option under the Self-Service menu. Here is your **Temporary Self-Service PIN 4721**.

Your right to receive reasonable modification

If you have a disability that impacts your ability to meet the Community Engagement requirement, you are entitled to reasonable modification of the program requirements so that you can participate. We can help you with applying for an exemption or good cause, getting information about appealing a suspension or disenrollment, reporting your Community Engagement hours, and reading our letters and program rules. If you are unable to do some or all of the 100 hours because of your disability, we can reduce the number of hours that you are required to participate in or, if you qualify for an exemption, we can exempt you entirely from the Community Engagement requirement.

We are happy to provide you with additional services such as assistance with understanding the Granite Advantage program. Some examples of things we can explain include, but are not limited to, departmental letters, eligibility requirements, exemption requirements, how to apply for an ADA exemption, program benefits, how to establish eligibility, and how to meet and report Community Engagement activities to maintain eligibility.



**Licensed Medical Professional Certification of Medical Frailty
 Granite Advantage Health Care Program**

This certification is to be completed by a licensed medical professional who is qualified to assess the beneficiary for "medical frailty". This certification will be used to support the determination that the beneficiary is medically frail and exempt from the community engagement requirement for the Granite Advantage Health Care Program (Granite Advantage).

The beneficiary **MUST** return this form along with a copy of the BFA Form 320A Beneficiary Authorization for Licensed Medical Professional to Release Protected Health Information to the Department. The forms may be sent by mail (to the address above), by fax to 603-271-5623, by submitting the forms through NH EASY, or bringing them to a local district office. The forms can be submitted through NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the forms. A beneficiary may submit the forms to NH EASY or bring them to their district office **only** if the licensed medical professional has certified that the beneficiary is medically frail.

"Medically frail" means a beneficiary, as defined in 42 CFR 440.315 (f), with a disabling mental disorder, chronic substance use disorder, serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living as certified by a medical professional.

Part I. Member Information (please print)

Medicaid ID#: 88090920917

| | | | | | | | | |
|--|--|------------------------|--|--|--|--|-------------------|----------|
| Name: Jane Doe | | | | | | | | |
| Residential Street Address (if homeless write N/A): | | City, State, ZIP Code: | | | | | | |
| Date of Birth: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | Gender: M F | Phone #: |
| | | | | | | | | |

Part II. Licensed Medical Professional Certification

As a licensed medical professional caring for this beneficiary, I hereby certify that the beneficiary is medically frail based on the beneficiary having one or more of the conditions identified in Part III below:

Part III. Medically Frail Condition

| Please check ALL the appropriate circles in the table that best define the medically frail condition of the beneficiary: | |
|--|---|
| Definition | Category |
| Individuals with disabling mental health disorders | <input type="radio"/> Psychotic disorder <input type="radio"/> Schizophrenia <input type="radio"/> Schizoaffective disorder |

(over)

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| | |
|--|---|
| Individuals with disabling mental health disorders (continued) | <input type="radio"/> Major depression <input type="radio"/> Bipolar disorder <input type="radio"/> Delusional disorder <input type="radio"/> Obsessive-compulsive disorder <input type="radio"/> Other mental health condition: specify _____ |
| Individuals with substance use disorders | <input type="radio"/> The beneficiary has a diagnosis of substance use disorder consistent with DSM-V* criteria. <small>*DSM-V means the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.</small> |
| Individuals with serious and complex medical conditions | <input type="radio"/> The individual meets criteria for hospice services, OR <input type="radio"/> The individual has a serious and complex medical condition AND the condition significantly impairs the ability to perform one or more activities of daily living (ADLs). |
| Individuals with a physical disability | <input type="radio"/> The individual has a physical disability AND the condition significantly impairs the ability to perform one or more activities of daily living (ADLs). |
| Individuals with an intellectual or developmental disability | <input type="radio"/> The individual has an intellectual disability or a developmental disability as described below AND the condition significantly impairs the ability to perform one or more activities of daily living (ADLs) <ul style="list-style-type: none"> • Intellectual Disability means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior • Developmental Disability means a disability attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or a specific learning disability (or any other condition of an individual found to be closely related to an intellectual disability as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that for persons with an intellectual disability), that is manifested before the age of 22 and that reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of a lifelong or extended duration and are individually planned and coordinated. |

Additional provider notes including any other considerations that should be given to support "Medical Frailty" of this individual:

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

| | | |
|-------------------------------|-------|----------------------|
| Provider Name (Please print): | Date: | Contact #: () |
|-------------------------------|-------|----------------------|

Provider Signature: _____ NPI #:

Beneficiary Authorization for Licensed Medical Professional to Release Protected Health Information
Granite Advantage Health Care Program

This form authorizes a licensed medical professional to release to the Department of Health and Human Services (Department) a beneficiary's protected health information (PHI) related to the licensed medical professional's certification of the beneficiary as medically frail. This form should be completed by the beneficiary and given to the licensed medical professional who is completing the Licensed Medical Professional Certification of Medical Frailty Form.

The beneficiary **MUST** return a copy of this form along with a copy of the Licensed Medical Professional Certification of Medical Frailty Form to the Department. The forms may be sent to the Department by mail at the address above, by fax to 603-271-5623, by submitting forms to NH EASY, or bringing the forms to a local district office. The forms can be submitted through NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the forms. A beneficiary may upload the forms to NH EASY or bring the forms to their local district office **only** if the licensed medical professional has certified that the beneficiary is medically frail.

Part I. Beneficiary Information (please print)

| | | |
|---|-----------------------------|--------------------------|
| Last Name: | First Name, Middle Initial: | Date of Birth MM/DD/YYYY |
| Residential Street Address (if homeless write N/A): | City, State, Zip Code: | Phone #: () |

Part II. Purpose of the Disclosure The purpose of the disclosure of PHI pursuant to this release is to verify the licensed medical professional certification that the beneficiary is medically frail and that the beneficiary is accordingly exempt from the Granite Advantage Health Care Program community engagement requirements. I understand that if I do not authorize the release of this information, I will not be able to demonstrate that I qualify for an exemption with the necessary completion of the Licensed Medical Professional Certification of Medical Frailty Form.

Please check all that apply below:

- I hereby authorize the following licensed medical professional to disclose my protected health information for the purposes described above:

Name of Medical Professional: _____
Organization: _____ Telephone #: (____) ____ -- _____
Address: _____

- In addition, I hereby authorize the following specific disclosures (Place your initials on the line by those statements which apply)

_____ I specifically authorize the release of my mental health treatment records.
_____ I specifically authorize the release of my HIV and AIDS results and/or treatment.

_____ I specifically authorize the release of my alcohol and/or drug abuse treatment records in accordance with 42 CFR Part 2.

_____ Other (specify): _____.

I give authorization for my protected health information to be released to the following individual or organization:

Name: Granite Advantage Health Care Program Manager

Organization: Department of Health and Human Services

Address: DHHS, Granite Advantage Health Care Program, P.O. Box 3778, Concord, NH 03302-3778 or Fax# 603-271-5623

I understand this authorization may be revoked by notifying the Department of Health and Human Services in writing to the address above.

This authorization will expire one year from the date it is signed.

Signature of Beneficiary or Duly Authorized Legal Representative

Date

If you have any questions regarding this form, please call the Department's Medicaid Customer Services number at 1-844-275-3447 (1-844-ASK-DHHS).

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(A)

Get help in your language

English (English)

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-844-275-3447 (TTY: 1-800-735-2964)

Español (Spanish)

ATENCIÓN: Si usted habla español, tiene a disposición servicios de asistencia lingüística, gratuitos. Llame al 1-844-275-3447 (TTY: 1-800-735-2964)

Ikinyarwanda (Kinyarwanda)

IKITONDERWA: Nuvuga Ikinyarwanda, serivisi z'ubufasha bw'ururimi, zitishyurwa, urazibona. Hamagara 1-844-275-3447 (TTY: 1-800-735-2964)

नेपाली (Nepali)

ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंको लागि निःशुल्क नेपाली भाषा सहायता सेवा उपलब्ध छ । 1-844-ASK-DHHS (TTY: 1-800-735-2964) मा फोन गर्नुहोस् ।

Kiswahili (Swahili)

TAHADHARI: Ikiwa unaongea Kiswahili, huduma za usaidizi wa lugha ya Kiswahili, zinapatikana kwako bila malipo. Piga simu 1-844-275-3447 (TTY: 1-800-735-2964)

(Arabic) العربية

انتباه: إذا كنت تتحدث العربية، هناك خدمة ترجمة مجانية متاحة لك. الرجاء الاتصال بالرقم 1-844-275-3447 (TTY: 1-800-735-2964)

Kreyòl Ayisyen (Haitian Creole)

ATANSYON: Si ou pale Kreyòl Ayisyen, Nou mete sèvis asistans lang ki gratis disponib pou ou. Rele nan nimewo 1-844-275-3447 (TTY: 1-800-735-2964)

Ikirundi (Kirundi)

MENYA NEZA: Ukaba uvuga Ikirundi, urashobora kuronswa ubufasha mu gusiguza muzindi ndimi kubuntu. Hamagara kuri 1-844-275-3447 (TTY: 1-800-735-2964)

Português (Portuguese)

ATENÇÃO: Se você fala Português temos serviços gratuitos de assistência linguística disponíveis para você. Ligue para o número 1-844-275-3447 (TTY: 1-800-735-2964)

Soomaali (Somali)

DIGTOONI: Haddii aad ku hadasho Soomaali, adeegyada caawimada luqadda, bilaash ah, ayaa lagu heli karaa. Wac 1-844-275-3447 (TTY: 1-800-735-2964)

Maay (Maay/Mai Mai)

FIIRA QAAS EH: Hattii ka koothaasa af Maay, atheegatha kaalmatha afka, bilaash eh, yaa la kin helee. Han weer 1-844-275-3447 (TTY: 1-800-735-2964)

Get help in your language

မြန်မာစကား (Burmese)

ဂရုပြုရန်- သင်သည် ဗမာစကား ပြောတတ်ပါက သင့်အတွက် အခမဲ့ ဗမာဘာသာ အကူအညီ ဝန်ဆောင်မှုများအား ရရှိနိုင်ပါသည်။ 1-844-275-3447 (TTY: 1-800-735-2964) သို့ ခေါ်ဆိုပါ။

Français (French)

ATTENTION: Si vous parlez français, des services d'assistance linguistique sont mis à votre disposition gratuitement. Appelez le 1-844-275-3447 (TTY: 1-800-735-2964)

Bosanski (Bosnian) / Hrvatski (Croatian)

PAŽNJA: Ako govorite Bosanski/Hrvatski, besplatne prevodilačke usluge su vam na raspolaganju. Pozovite 1-844-275-3447 (TTY: 1-800-735-2964)

Tiếng Việt (Vietnamese)

LƯU Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ tiếng Việt miễn phí sẵn có dành cho quý vị. Hãy gọi 1-844-275-3447 (Dành cho người khiếm thính: TTY: 1-800-735-2964)

普通话 (Mandarin Chinese)

注意：如果您讲普通话，可免费享受普通话帮助服务。请拨打1-844-275-3447 (TTY: 1-800-735-2964)

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-844-275-3447 (TTY: 1-800-735-2964) 'ਤੇ ਕਾਲ ਕਰੋ

Русский (Russian)

ВНИМАНИЕ: Если вы говорите по-русски, переводческие услуги могут предоставляться вам бесплатно. Звоните 1-844-275-3447 (TTY: 1-800-735-2964)

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, διατίθενται δωρεάν γλωσσικές υπηρεσίες υποστήριξης. Καλέστε 1-844-275-3447 (TTY: 1-800-735-2964)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएँ मुफ्त उपलब्ध हैं। कॉल करें 1-844-275-3447 (TTY: 1-800-735-2964)