

○	Community Service or Public Service (Volunteer) Enter total hours here →	
	Please list the agency name, contact person, contact information (phone or email), date(s) and number of hours that you worked for each place where you volunteered or provided community or public service during the month. Enter the total number of hours for the month above.	

○	Caregiver Services For a Non-Dependent Relative or Other Person With a Disabling Condition Enter total hours here →	
	Please provide the name and contact information (phone or email) for the non-dependent relative or other person with a disabling condition for whom you provided caregiver services. Please describe the caregiver services that you provided and indicate the number of hours that these services were provided during the month. Enter the total number of hours for the month above.	

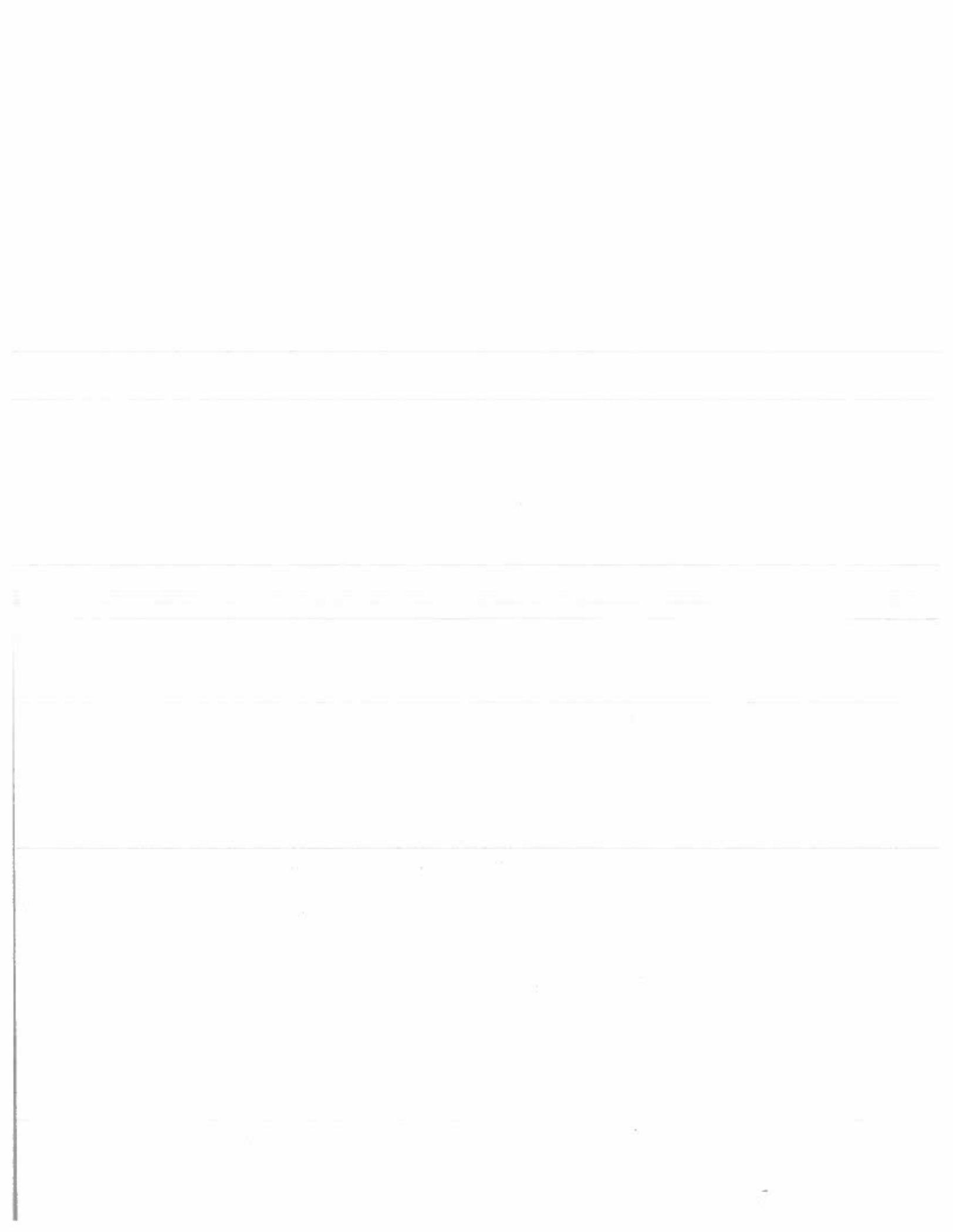
○	Participation in Outpatient Substance Use Disorder Services Enter total hours here →	
	Please identify the agency or organization where you are receiving services and the number of hours not exceeding 40 hours, that you participated in those services during the month. Enter the total number of hours for the month above.	

Instructions for Completing the Form

1. Complete your beneficiary information and sign and date the top section of the form.
2. After reviewing the descriptions of qualifying community engagement activities below, fill in the circle in the far-left column of the row which applies to the qualifying community engagement activity that you are reporting.
3. Enter the total number of hours for the month in the far right column of the row which applies to the qualifying community engagement activity that you are reporting.
4. You MUST return this form to the Department of Health and Human Services either in person, by mail at the address on the top of the first page, by fax to (603) 271-5623, or by submitting the form through NH EASY. The form can be submitted to NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the form.

Descriptions of Qualifying Community Engagement Activities

<p>Job Search and Job Readiness</p>	<p>This activity includes but is not limited to participation in job search or job training activities offered through the Department of Employment Security or through other job search or job readiness assistance program such as Workforce Innovation and Opportunity Act (WIOA) or Work Ready New Hampshire. Time spent in any assessment, training, enrollment or case management activity that is necessary for participation in this activity is credited toward job search and job readiness assistance hours. Attestation must include the type and duration of the activity.</p>
<p>Community Service or Public Service (Volunteer)</p>	<p>This activity requires attestation of where and when the community or public service was performed and the number of hours worked. The attestation must include contact information for the community service or public service agency.</p>
<p>Caregiver Services For a Non-Dependent Relative or Other Person With a Disabling Condition</p>	<p>This activity is for caregiving services provided to a non-dependent relative or other person with a disabling medical, mental health or developmental condition. It requires attestation by the beneficiary as to the services provided including the name of the non-dependent relative or other person with a disabling condition and the number of hours of caregiving services provided.</p>
<p>Participation in Outpatient Substance Use Disorder Services</p>	<p>This activity is for participation in ASAM Level 1 outpatient substance use disorder services, including medication assisted treatment, and recovery supports. It requires self-attestation of the number of hours that the beneficiary participated in the services up to 40 hours per month.</p>



○	Enrollment at an Accredited Community College, College or University <p style="text-align: right;">Enter total hours here →</p>	
	<p>Please provide:</p> <p>The name of the college or university: _____;</p> <p>The semester start date (MM,YYYY): _____;</p> <p>The semester end date (MM,YYYY): _____.</p> <p><u>Attach a copy of your class schedule</u> which indicates the number of credit hours assigned for the enrolled classes. Multiply the number of credit hours for all enrolled classes by 4.33 and enter the total number of hours to be credited each month for the duration of your participation in the activity.</p>	
○	Vocational Educational Training <p style="text-align: right;">Enter total hours here →</p>	
	<p>Please provide:</p> <p>The name of the institution: _____;</p> <p>The training start date (MM,YYYY): _____;</p> <p>The training end date (MM,YYYY): _____.</p> <p><u>Attach documentation of your enrollment</u> in the training program. Community engagement hours will be credited at 100 hours per month for the duration of your participation in the training program activity.</p>	
○	Education Directly Related to Employment (Beneficiary Has Not Received a High School Diploma or GED) <p style="text-align: right;">Enter total hours here →</p>	
	<p>Please provide:</p> <p>The name of the program or activity: _____;</p> <p>The program or activity start date (MM,YYYY): _____;</p> <p>The program or activity end date (MM,YYYY): _____.</p> <p><u>Attach documentation of your enrollment</u> in the program or activity. Community engagement hours will be credited at 100 hours per month for the duration of your participation in the program or activity.</p>	

O	High School or Equivalent	Enter total hours here →
<p>Please provide:</p> <p>The name of the high school or equivalency program: _____;</p> <p>The high school or equivalency program start date (MM,YYYY): _____;</p> <p>The high school or equivalency program end date (MM,YYYY): _____.</p> <p><i>Attach documentation of your enrollment</i> in the high school or equivalency program. Community engagement hours will be credited at 100 hours per month for the duration of your participation in high school or an equivalency program.</p>		

Instructions for Completing the Form

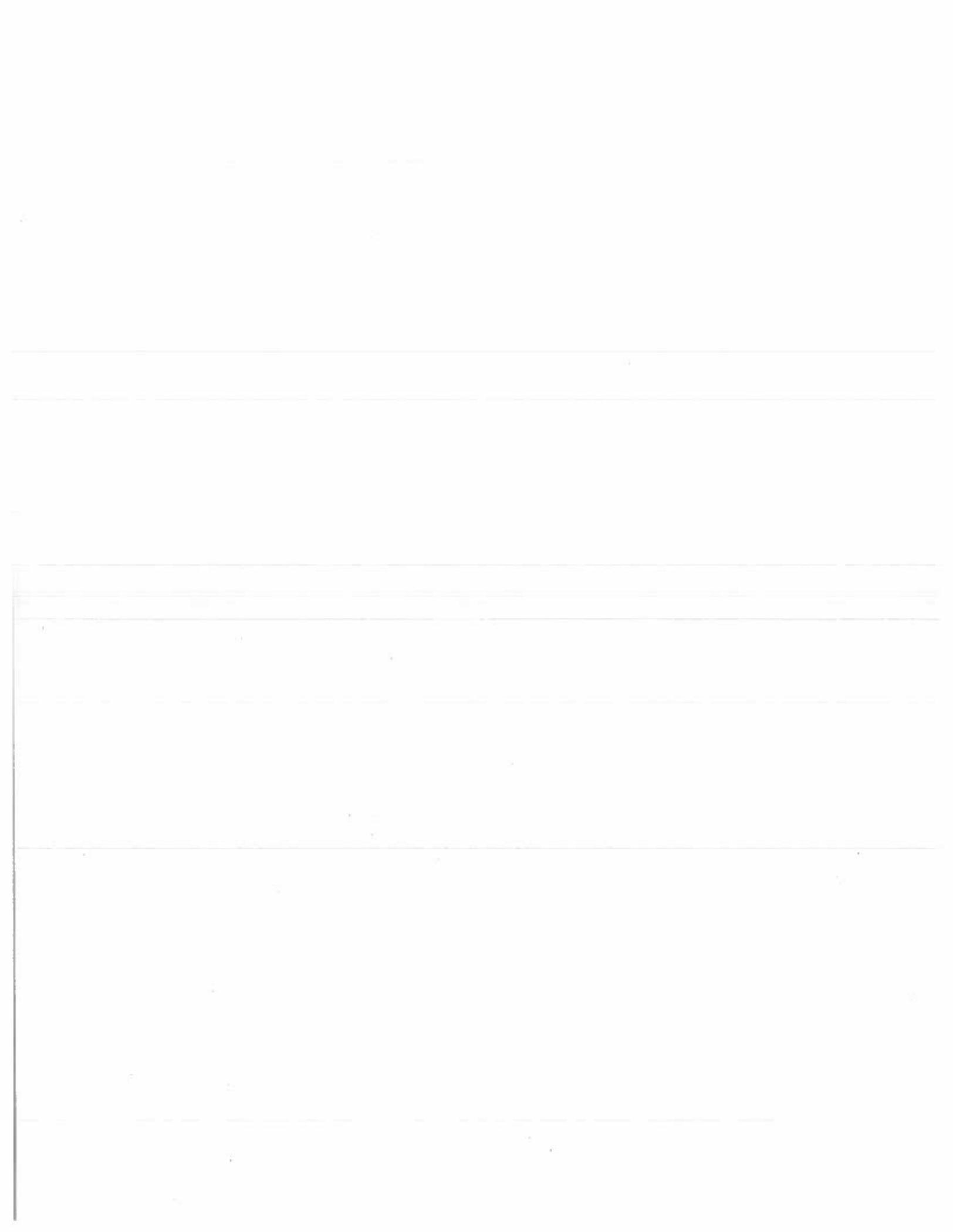
1. Please complete your beneficiary information and sign and date the top section of the form on the first page.
2. After reviewing the descriptions of qualifying community engagement activities below, fill in the circle in the far-left column of the row which applies to the qualifying community engagement activity that you are reporting.
3. Enter the total number of hours to be credited each month for the duration of your participation in the activity in the far right column of the row which applies to the qualifying community engagement activity that you are reporting.
4. Attach the necessary documentation to the form.
5. You MUST return this form to the Department of Health and Human Services either in person, by mail at the address at the top of the first page, by fax to (603) 271-5623 or by submitting the form (and the required documentation) to NH EASY. The form and required documentation can be submitted through NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the form.

Descriptions of Qualifying Community Engagement Activities

Job Skills Training Related to Employment	This activity requires documentation of enrollment in a job skills training program that includes the duration of the program and the number of hours that the beneficiary is participating in the activity.
Enrollment at an Accredited Community College, College or University	This activity requires enrollment at an accredited community college, college or university that is counted on a credit hour basis. Documentation of enrollment must include a copy of the beneficiary's class schedule, the number of credit hours assigned for the enrolled class(es) and the semester begin and end date. The number of community engagement hours that are credited toward the community engagement requirement each month is determined by multiplying the number of credit hours assigned for the enrolled class(es) by 4.33.
Vocational Educational Training	This activity requires documentation of enrollment in a vocational education training program that includes the duration of the activity. Community engagement hours are credited at 100 hours per month for the duration of the beneficiary's participation in the activity not to exceed 12 months.
Education Directly Related to Employment (Beneficiary Has Not Received a High School Diploma or GED)	This activity is for participation in education directly related to employment in the case of a beneficiary who has not received a high school diploma or certificate of high school equivalency. The activity requires documentation of enrollment that includes the duration of the activity. Community engagement hours are credited at 100 hours per month for the duration of the beneficiary's participation in the activity.

High School or
Equivalent

This activity requires satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence and requires documentation of enrollment that includes the duration of the activity. Community engagement hours are credited at 100 hours per month for the duration of the beneficiary's participation in the activity.



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).

Date of Birth:

M		M		D		D		Y		Y		Y		Y
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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):

M		M		Y		Y		Y		Y
---	--	---	--	---	--	---	--	---	--	---

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.
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 NH EASY, or bringing the form to your local district office. Log on to nheasy.nh.gov, go to "MANAGE COMMUNITY ENGAGEMENT", click "Request Exemption", select the exemption, and submit the form. 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

Participation in State Certified Drug Court Program	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 court order.
Parent/Caretaker of Dependent Child Under 6	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.
Pregnant or Within 60 Days Post-partum	The beneficiary is pregnant or within 60 days post-partum. Enter the due date.
ADA Disability	The beneficiary has a disability as defined by the Americans with Disabilities Act (ADA) 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 ADA disability.
Caretaker Residing With Immediate Family Member with ADA Disability	The beneficiary resides with an immediate family member who has a disability as defined by the Americans with Disabilities Act (ADA) 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.

<p>Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient Treatment</p>	<p>The beneficiary is unable to participate in the requirements due to serious illness, hospitalization, incapacity, or treatment, including inpatient or residential outpatient 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.</p>
<p>Hospitalization or Serious Illness</p>	<p>The beneficiary 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.</p>
<p>Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness</p>	<p>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.</p>
<p>Parent/Caretaker of Developmentally Disabled Child</p>	<p>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.</p>
<p>Parent/Caretaker of Family Member Requiring Care</p>	<p>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.</p>

NH Department of Health and Human Services
 Granite Advantage Health Care Program
 P.O. Box 3778, Attn: Granite Advantage Health Care Program Manager
 Concord, NH 03302-3778
 Fax: 603-271-5623

BFA Form 331

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 320 Beneficiary Authorization for Licensed Medical Professional to Release Protected Health Information 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 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 the forms 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. Beneficiary Information (please print)

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

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 boxes in the table that best defines the medically frail condition of the beneficiary:	
Definition	Category

Individuals with disabling mental health disorders	<input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Delusional disorder <input type="checkbox"/> Obsessive-compulsive disorder <input type="checkbox"/> Other mental health condition: specify
Individuals with substance use disorders	<input type="checkbox"/> The beneficiary has a diagnosis of substance use disorder consistent with DSM-V* criteria. *DSM-V means the 5 th edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
Individuals with serious and complex medical conditions	<input type="checkbox"/> The individual meets criteria for hospice services, OR <input type="checkbox"/> 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="checkbox"/> 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="checkbox"/> 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 MM/DD/YYYY (May not exceed one year).

Provider Name (Please print):	NPI #
Date	Contact #: ()

Provider Signature:



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 320 Beneficiary Authorization for Licensed Medical Professional to Release Protected Health Information 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 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 the forms 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. Beneficiary Information (please print)

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

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 boxes in the table that best defines the medically frail condition of the beneficiary:

Definition	Category
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Individuals with disabling mental health disorders	<input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Delusional disorder <input type="checkbox"/> Obsessive-compulsive disorder <input type="checkbox"/> Other mental health condition: specify
Individuals with substance use disorders	<input type="checkbox"/> 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="checkbox"/> The individual meets criteria for hospice services, OR <input type="checkbox"/> 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="checkbox"/> 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="checkbox"/> 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"> o Intellectual Disability means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior o 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 MM/DD/YYYY (May not exceed one year).

Provider Name (Please print):	NPI #
Date	Contact #: ()

Provider Signature: