NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management/Office of Managed Care

Medicaid Managed Care and Family Health Plus Enrollment Form

Applicant: Please print. Do not fill in shaded areas. Shaded areas are for official use only.

Head of Household (Last Name, First, MI)	Current Street Address, Apt #	City, State, ZIP	Case Number (if you have one and know it)

Primary Language	County	Phone Number where you can be reached	Does anyone enrolling have any other health insurance? ☐ Yes ☐ No	If Yes, what is the name of the insurance and what is the policy number?

Circle Program	Name of Plan you are enrolling in (Adults age 19 to 64 must pick a FHPlus Plan)	Last Name	First Name	Date of Birth mm/dd/yy	Sex M/F	ID# (from Medicaid Card if you have one)	Social Security # (optional if pregnant)	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID # of OB/GYN (check box if current provider)
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The information that I have given in my application is true to the best of my knowledge.

I know that in order to receive Family Health Plus benefits, I must join a managed care health plan. I also know that in some counties, joining a health plan may be required to receive Medicaid. I have been told whether my county requires Medicaid enrollees to join a health plan. I have been told what health plans are available to me in Family Health Plus and in Medicaid managed care. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing that I/we do not want to be in that health plan or unless I/we check this box ☐.

I have been told the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership. I know that in both Family Health Plus and Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice of at least three (3) PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I know that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in. I know that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid managed care, my child will be enrolled in the same health plan that I am in.

I consent to the release of any medical information about me and any members of my family for whom I can give consent;

- By my PCP, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
- By my health plan and any health care providers to SDOH and other authorized federal, state and local agencies for purposes of administration of the Medicaid, Child Health Plus and Family Health Plus programs; and
- By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment or health care operations.

I also agree that the information released for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke it.

If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

Applicant's Signature:	Date:	Other Adult Signature:	Date:

Date	Assisted by (Name/ID #)	Check if FE ☐	Location	Phone	**Mandatory** Managed Care County? ☐ Yes ☐ No	Was enrollee **educated** and given Managed Care information packet? ☐ Yes ☐ No

WHITE - Managed Care Organization YELLOW - LDSS PINK - Applicant GOLDENROD - Enrollment Facilitator

How to Complete the Medicaid Managed Care and Family Health Plus Enrollment Form

Do not fill in the shaded boxes. These will be filled in by social services workers, the managed care health plan and enrollment facilitators.

You will need to fill in the top part of the form if you want to join a managed care plan. The top part is also for parents or guardians of children who get Medicaid.

❶ **Head of Household:** This is the adult who is applying or the parent or guardian of the children in the household. Write in your name if you are the person who is the contact for Medicaid/FHPlus benefits at your house.

❷ **Current Street Address, City, State and Zip Code:**
Write in your current street address, city, state and zip code.

❸ **Case #:** Write in your case number, if you know it. If you do not know your case number, talk to someone at the social services office. If you have not been given a case number, leave blank.

❹ **Primary Language:** Write in the main language that you speak.

❺ **County:** Write in the county that gives you Medicaid/FHPlus. This is usually the county where you live.

❻ **Phone #:** Write in a phone number the plan can use to reach your household.

❼ **Check yes if:** you or any family member have other health insurance, then write in the name of the health plan or insurance company, and the policy number.

You need to fill in the middle part of the form for each person in your household who is joining a health plan. The facilitated enroller or a Social Services worker can help if you need it.

❽ **Name of Health Plan:** Write in the name of the health plan that you have chosen for each family member. **Remember** for FHPlus adults **must** enroll in a health plan to get services.

Adults can pick a FHPlus Plan or a different Medicaid Health Plan, in some counties. If your county has different choices for each program, you can do this by circling the program to the left of the health plan you picked. You will be enrolled in the health plan for the program you are eligible for. **Do not check the box.**

If you pick one plan and it serves both FHPlus and Medicaid managed care, you will be enrolled in that plan if you are found eligible.

❾ **Write in the last name, first name, date-of-birth, sex, Client Identification Number (if known), and Social Security Number.** Give this information for each family member.

❿ **Write in the name of the Primary Care Physician (PCP) for each person in the household.**
This is the doctor who you will see most of the time. If this is your doctor now, put a check mark in the next box. If this is a new doctor for you, do not check the box. Women should also write in the name of the OB/GYN doctor they chose if the managed care plan also lets women choose an OB/GYN doctor. The managed care plan will provide the doctors' ID numbers.

You should call the doctor you want to make sure the doctor is in the plan you want. If this is a new doctor for you, you need to make sure the doctor is accepting new patients.

Applicant Signature: Please read the form to be sure what you wrote is correct. If needed you should contact your case worker or someone from the managed care health plan. If all the facts on the form are correct, please read the "Application Certification", sign the form on the bottom, and write in the date when you signed it. The signature of each applying adult is necessary for consent of release of information.