

A Whole New Concept of Caring

Senior Whole Health

Enrollment Application Forms



SENIOR WHOLE HEALTH

Simple. Secure. Independent.

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SENIOR WHOLE HEALTH

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SENIOR WHOLE HEALTH

Medicare Advantage Enrollment Form

Name (Last, First, Middle Initial)		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #
Phone (Home)	Phone (Cell)	
Permanent Residence Street Address		Apartment #
City	State	Zip
Mailing Address (Only if different from Residency)		Apartment #
City	State	Zip
Emergency Contact (Optional)	Contact's Phone Number	Contact's Relationship
E-mail Address (Optional)		
Primary Spoken Language		
Primary Written Language		

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this selection.

- Please fill in these blanks so they match your red, white and blue Medicare card.

— OR —

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare **Part A** and **Part B** to join a Medicare Advantage Plan

SAMPLE ONLY

Name _____

Gender: M F

Medicare Claim Number _ _ _ - _ - - _ _ _ _ _

Is Entitled To Effective Date

Hospital (Part A) _____

Medical (Part B) _____



SENIOR WHOLE HEALTH

Medicare Advantage Enrollment Form

Please Provide Your Medicaid Insurance Information

Are you enrolled in your State Medicaid program? Yes No

Please take out your Medicaid Card to complete this section or attach a copy of your Medicaid Card.

You must have Medicaid to join this plan.

Name _____

Medicaid ID Number _____

Type of Medicaid _____

Please Read and Answer These Important Questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "Yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Do you have other prescription drug coverage? Yes No

If "Yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____ Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "Yes", please provide the following information:

Name of Institution _____

Address (Number and Street) _____

4. Do you or your spouse work? Yes No

Please choose the name of a Primary care Physician (PCP), clinic or health center (if required):



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Medicare Advantage Enrollment Form

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Senior Whole Health is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Senior Whole Health or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Senior Whole Health serves a specific service area. If I move out of the area that Senior Whole Health serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Senior Whole Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Senior Whole Health when I receive it to know which rules I must follow in order to receive coverage with the Medicare Advantage plan.

I understand that beginning on the date Senior Whole Health coverage begins, I must get all of my health care from Senior Whole Health, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare and while out of the county except for limited coverage in Canada and Mexico. Services authorized by Senior Whole Health and other services contained in my Senior Whole Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Senior Whole Health WILL PAY FOR THE SERVICES.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the content of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Senior Whole Health or by Medicare.

Your Signature	Date
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If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ - _____ Relationship to Enrollee _____

Office Use Only:

Name of Staff Member (If assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____



SENIOR WHOLE HEALTH

Medicaid Advantage and Medicaid Advantage Plus Enrollment Form

Name (Last, First, Middle Initial)			
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Case Number	
Client Identification # (CIN)(NYS Benefit Card)			
Social Security #		HIC Number (Medicare)	
Address			Apartment #
City	State	Zip	County
Phone (Home)		Phone (Cell)	
Phone (Other)			
Primary Care Provider			
Primary Language	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Haitian Creole	<input type="checkbox"/> Other _____

Attestation

The information that I have given in my application is true to the best of my knowledge.

I understand enrollment in Medicaid Advantage or Medicaid Advantage Plus is voluntary.

I have been told the rights and benefits that I will have as a member of Medicaid Advantage or Medicaid Advantage Plus and the conditions of participation. I know that I must be enrolled in the same health plan's Medicare Advantage product to enroll or stay enrolled in Medicaid Advantage or Medicaid Advantage Plus.



SENIOR WHOLE HEALTH

Medicaid Advantage and Medicaid Advantage Plus Enrollment Form

I Consent to the Release of any Medical Information About Me:

- By my primary care provider (PCP), by any other health care provider, or by the New York State Department of Health (SDOH) to **SENIOR WHOLE HEALTH** and any health care providers involved in caring for me as reasonably necessary for **SENIOR WHOLE HEALTH** 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 **SENIOR WHOLE HEALTH** and any health care providers to SDOH and other authorized federal, state and local agencies for purpose of administration of the Medicare and Medicaid programs, and
- By **SENIOR WHOLE HEALTH** 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 HIV/AIDS, mental health, or alcohol substance abuse information about me may be released, to the extent permitted by law, for as long as I remain enrolled in **SENIOR WHOLE HEALTH**. I know that I can revoke this consent at any time by notifying **SENIOR WHOLE HEALTH** in writing, except that this would not apply to information that has already been released.

I understand that other federal, state, and local laws may protect the confidentiality of my personal health information.

_____ I wish to enroll in **SENIOR WHOLE HEALTH** Medicaid Advantage and understand that enrollment is voluntary.

_____ If at the time of my enrollment, it is determined that I am eligible for long-term care services per New York State Department of Health rules and regulations,

- I agree to enroll in **SENIOR WHOLE HEALTH** Medicaid Advantage Plus, and I understand my enrollment in **SENIOR WHOLE HEALTH** Medicaid Advantage Plus is voluntary.
- I will choose to stay in **SENIOR WHOLE HEALTH** Medicaid Advantage and obtain my long-term care services from regular Medicaid. I understand that I can change my mind should I want to enroll in **SENIOR WHOLE HEALTH** Medicaid Advantage Plus.

_____ If, during the course of enrollment in **SENIOR WHOLE HEALTH** Medicaid Advantage, I become eligible for **SENIOR WHOLE HEALTH** Medicaid Advantage Plus,

- I agree to enroll in **SENIOR WHOLE HEALTH** Medicaid Advantage Plus, and I understand my enrollment in **SENIOR WHOLE HEALTH** Medicaid Advantage Plus is voluntary.
- I will choose to stay in **SENIOR WHOLE HEALTH** Medicaid Advantage and obtain my long-term care services from regular Medicaid. I understand I can change my mind should I want to enroll in **SENIOR WHOLE HEALTH** Medicaid Advantage Plus.

_____ I have received and have had the Member Handbook(s) explained to me which includes the rules and responsibilities of plan membership and a description of covered and non-covered.

_____ I agree to participate in **SENIOR WHOLE HEALTH** according to the terms and conditions described in the Member Handbook(s).



SENIOR WHOLE HEALTH

Medicaid Advantage and Medicaid Advantage Plus Enrollment Form

_____ As a participant, I agree to receive all covered service from **SENIOR WHOLE HEALTH'S** network of providers. Further, I understand that I must choose my PCP and any specialty physician from **SENIOR WHOLE HEALTH'S** list of network providers. I have been given a copy of the provider network list.

_____ I understand that my anticipated date of enrollment is _____.

_____ I understand that my Enrollment Application must be approved by the local county department of social services.

_____ I understand that as a participant, I agree to allow all my service providers and the health information (PHI) with family members or other persons who are involved in my treatment plan or payment of my services, as designated below:

_____ I understand that as a participant, I agree to allow all my service providers and the Senior Whole Health staff to share information and communicate regarding my medical conditions and treatment plans.

_____ I understand that Senior Whole Health staff may at times share my personal health information (PHI) with family members or other persons who are involved in my treatment plan or payment of my services, as designated below:

Name of Designee	Relationship	Phone
Name of Designee	Relationship	Phone
Name of Designee	Relationship	Phone

Print Participant's Name	Signature of Participant	Date
Print Name of Family Member or Guardian (if applicable)	Signature of Family Member or Guardian (if applicable)	Date
Print Witness's Name	Signature of Witness	Date
Print Intake Specialist's Name	Signature of Intake Specialist	Date

Authorized Plan Representative Use Only

SWH Certification: Medicare Advantage Application complete for CMS Submission: Date _____