Medicaid Advantage Plus/
Medicare Advantage Enrollment Application

New York City

Senior Whole Health of New York, Inc. complies with applicable Federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-353-0185 (TTY/TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-353-0185 (TTY/TDD: 711).

注意：如果您说除英语之外的语言，我们可以为您提供免费的语言援助 服务。电话: 1-877-353-0185 (TTY/TDD: 711)。
English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-353-0185 (TTY/TDD: 711).


Simplified Chinese: 注意：如果您说除英语之外的语言，我们可以为您提供免费的语言援助服务。电话：1-877-353-0185 (TTY/TDD: 711)。

Traditional Chinese: 注意：如果您說除英語之外的語言，我們可以為您提供免費的語言援助服務。電話：1-877-353-0185 (TTY/TDD: 711)。

Chinese Mandarin: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-353-0185 (TTY/TDD: 711)。

Chinese Cantonese: 注意：如果您講嘅唔係英文，可以用免費嘅語言支援服務，電話：1-877-353-0185 (TTY/TDD: 711)。


Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-353-0185 (TTY/TDD: 711)まで、お電話にてご連絡ください。


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-353-0185 (TTY/TDD: 711) पर कॉल करें।

Khmer: ជូនដំណឹង៖ ប្រសិនបើលោកអ្នកនិយាយភាសាក្រៅពីភាសាអង់គ្លេស អ្នកអាចប្រើស្រវឹងជំនួយភាសាឥតគិតថ្លែង។ សូមទូរស័ព្ទទៅល្រខ 1-877-353-0185 (TTY/TDD: 711)។

Gujarati: ધ્યાન આપો: જો તમે અંગ્રેજી બોલતા હોય, તો તમારા માટે ભાષા સહાયતા સેવાઓ, નિઃશુલ્ક ઉપલબ્ધ છ. 1-877-353-0185 (TTY/TDD: 711) પર કૉલ કરો.

Bengali: ইংরাজি মনোযোগ দিন: আপনি যদি ইংরাজি ভাষা ব্যতীত কোন অন্য ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে, ভাষা সহায়তা সম্বন্ধীয় পরিষেবা উপলব্ধ। ফোন করুন এই নম্বরে 1-877-353-0185(TTY/TDD:711).


Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبان بیشتری را به اشتراک گزاری می کنید. این خدمات را از این شماره می توانید دریافت کنید: 1-877-353-0185 (TTY/TDD: 711)

Urdu: توجہ دیں: اگر آپ انگریزی کی علاوہ کونی اور زبان بولتے ہیں تو اپ کے لیے زبان سے متعلق مدد، مفت میں، دستیاب ہے 1-877-353-0185 (TTY/TDD: 711)


Medicaid Advantage Plus
Enrollment Application

<table>
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<tr>
<th>Name (Last, First, Middle Initial)</th>
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<tbody>
<tr>
<td>Date of Birth</td>
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<tr>
<td>Client Identification # (CIN)(NYS Benefit Card)</td>
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<tr>
<td>Social Security #</td>
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<tr>
<td>Address</td>
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<tr>
<td>City</td>
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<tr>
<td>Phone (Home)</td>
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<td>Phone (Other)</td>
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<td>Primary Care Provider</td>
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<tr>
<th>Primary Language</th>
<th>English</th>
<th>Spanish</th>
<th>Russian</th>
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<tr>
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<td>Chinese</td>
<td>Haitian Creole</td>
<td>Other</td>
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Attestation

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

I understand enrollment in Medicaid Advantage Plus is voluntary.

I have been told the rights and benefits that I will have as a member of 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 Plus.
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 OF NEW YORK** and any health care providers involved in caring for me as reasonably necessary for **SENIOR WHOLE HEALTH OF NEW YORK** 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 OF NEW YORK** 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 OF NEW YORK** 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 OF NEW YORK**. I know that I can revoke this consent at any time by notifying **SENIOR WHOLE HEALTH OF NEW YORK** 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 OF NEW YORK Medicaid Advantage Plus**, and I understand my enrollment in **SENIOR WHOLE HEALTH OF NEW YORK Medicaid Advantage Plus** is voluntary.

_____ 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 services.

_____ I agree to participate in **SENIOR WHOLE HEALTH OF NEW YORK** according to the terms and conditions described in the Member Handbook(s).
As a participant, I agree to receive all covered service from **SENIOR WHOLE HEALTH OF NEW YORK**’s network of providers. Further, I understand that I must choose my PCP and any specialty physician from **SENIOR WHOLE HEALTH OF NEW YORK**’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 New York Medicaid Choice.

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

I understand that Senior Whole Health of New York 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:

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

<table>
<thead>
<tr>
<th>Name of Designee</th>
<th>Relationship</th>
<th>Phone</th>
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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 ____________________________
Please provide your Medicare insurance information.

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Medicare Number</th>
<th>Gender:</th>
<th>Is Entitled To</th>
<th>Effective Date</th>
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<tr>
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<td>Hospital (Part A)</td>
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<td>Medical (Part B)</td>
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Please Read and Answer These Important Questions:

1. Do you have End Stage Renal Disease (ESRD)?  □ Yes  □ No
   If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.

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.
   Will you have other prescription drug coverage in addition to Senior Whole Health of New York?  □ 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 & Phone Number of Institution (number and street) ____________________________

4. Are you enrolled in your State Medicaid program?  □ Yes  □ No
   If yes, please provide your Medicaid number: ________________________

5. Do you or your spouse work?  □ Yes  □ No
   Please choose the name of a Primary Care Physician (PCP), clinic or health center:
   Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:  □ Spanish  □ Interpreter to read information  □ Large print  □ Braille
   Please contact Senior Whole Health of New York at 1-877-353-0185 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. - 8 p.m., 7 days a week. TTY/TDD users should call 711.

Please Read This Important Information

**STOP**

If you currently have health coverage from an employer or union, joining Senior Whole Health of New York could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Whole Health of New York. Read the communications your employer or union sends you.
If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.
By completing this enrollment application, I agree to the following:

SENIOR WHOLE HEALTH OF NEW YORK (SWHNY) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. 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. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances. SWHNY members can disenroll at any time during the year because there are special rules for individuals who have both Medicare and Medicaid coverage.

SWHNY serves a specific service area. If I move out of the area that SWHNY 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 SWHNY, I have the right to appeal plan decisions about payment or services if I disagree. I will read the SWHNY Evidence of Coverage document from SWHNY when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date SWHNY coverage begins, I must get all of my health care from SWHNY, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by SWHNY and other services contained in my SWHNY Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR SWHNY WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with SWHNY, he/she may be paid based on my enrollment in SWHNY.

Release of Information: By joining this Medicare health plan, I acknowledge that SWHNY will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SWHNY will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 my behalf under the laws of the State where I live) 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 on request from Medicare.

Signature ____________________________________________ Today’s Date ________

If you are the authorized representative, you must sign above and provide the following information:

Name: ______________________________________________________________________

Address: _____________________________________________________________________

Phone Number: (_____) ______ - _________ Relationship to Enrollee ___________________

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _________________________

Plan ID #: _____________________________ Effective Date of Coverage: _________________

ICEP/IEP: _________ OEP: _________ AEP: _________ SEP (type): _________ Not Eligible: __________