nh healthy families™

Guide to Forms

If you have Internet access:

- Go online to **NHhealthyfamilies.com**.
- Create an online account and fill out the forms that fit your healthcare needs.
- Learn about our rewards program, myhealthpays®*
- See our list of doctors.
- Complete your Health Risk Assessment Screening

*Some restrictions and limitations apply. Each member can earn up to $250 in cash and non-cash goods and services through June 30 each year.

**This My Health Pays® Rewards Visa® Prepaid Card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted.

If you do not have Internet access:

- Fill out the forms in this booklet and mail them to us using the postage-paid **color-coded envelopes** included.
- Set up an appointment for a wellness visit with your PCP and receive a reward on your myhealthpays®* Visa® Prepaid Card**.
- Request our list of in-network doctors near you by calling **1-866-769-3085**.

How fast can you earn up to $30?* How about 10 minutes!

Complete your Health Risk Assessment Screening online or in the Forms Booklet in this packet within 30 days of enrollment and earn $30 on your myhealthpays® account. If after 30 days, you can earn $20. Existing members can earn $20 annually.*

- Complete the forms in this packet, or go online to print them out at **NHhealthyfamilies.com**.
- The forms are confidential.
- Fill out one form per member.
- If you need more forms for members in your household, call us at **1-866-769-3085**. We will mail more forms to you.
- If you have questions or need help understanding your forms, call Member Services at **1-866-769-3085**, or visit us online at **NHhealthyfamilies.com**.

1-866-769-3085
TDD/TTY (Hearing Impaired): 1-855-742-0123

Hours of Operation: Monday - Wednesday, 8 AM to 8 PM, Thursday & Friday, 8 AM to 5 PM

NHhealthyfamilies.com

21-1092-R1

MHP-CAID-20-NH-C-00067

Forms in this packet:

Fill out your Health Risk Assessment Screening within 30 days of enrollment and earn $30* on your myhealthpays®* Visa® Prepaid Card**. Contact us to find out more, 1-866-769-3085.

FORM:

- ***Health Risk Assessment Screening (HRA)***
- ***Notification of Pregnancy (NOP)***

SEND TO:

Medical Management Notifications
PO Box 2010
Farmington, MO 63640-9706

FORM:

- ***Primary Care Physician (PCP)***
- ***Ready for My Recovery***
- ***Authorization to Use and Disclose Health Information***

SEND TO:

NH Healthy Families
2 Executive Park Drive
Bedford, NH 03110-9983

*Some restrictions and limitations apply. Each member can earn up to $250 in cash and non-cash goods and services through June 30 each year.

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RETURN IN BLUE ENVELOPE

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Health Risk Assessment Screening

Please complete all sections that apply to you or your family member. The answers to these questions will help us see how we can best help you or your family member and will not affect your Medicaid benefits in any way. All answers are kept private. If you need help filling out this form, please call 1-866-769-3085. TDD/TTY users may call 1-855-742-0123.

*Indicates a required question

Member Information

Name of person filling out the form:

Relationship to Member:

☐ Self ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Child ☐ Other

*Member Name (Last,First):

*Medicaid ID: Date of Birth (MMDDYYYY):

*Gender: ☐ Female ☐ Male Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (List up to two):

☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Not Specified

*Spoken Language: ☐ English ☐ Spanish ☐ Other

Written Language: ☐ English ☐ Spanish ☐ Other

*What is the best telephone number to reach you?

What type of phone number is this? ☐ Home ☐ Cell ☐ Other

*Best Email address?

*How would you like us to contact you? ☐ Phone ☐ Mail ☐ Email ☐ Text ☐ Other

*Where do you live? ☐ Own/Rent ☐ Shelter ☐ Homeless ☐ Staying with family/friend ☐ Other

How many places have you lived in the past year? ☐ One ☐ Two ☐ Three or more

Do you feel safe at home?

☐ Yes, always ☐ Unsure ☐ Yes, sometimes ☐ No ☐ Choose not to answer

Do you have a reliable transportation to doctor visits?

☐ Always ☐ Sometimes ☐ Rarely or Never

Are you being treated for any of these conditions? (Check all that apply)

☐ Acquired Brain Disorder ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ HIV/AIDS

☐ Intellectual or Developmental Disability ☐ Lung Disease ☐ Sickle Cell Disease (not trait) ☐ Hepatitis

☐ Serious Physical Condition (such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)

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NH-HRAS-6003

☐ Stroke ☐ Transplant ☐ Other (please explain)

Child Only

☐ Juvenile Arthritis ☐ Developmental Issues ☐ Neonatal Abstinence Syndrome

Are you currently on IV antibiotics for more than 3 weeks? ☐ Yes ☐ No

Do you have constant pain? ☐ Yes ☐ No

If yes, how intense is the pain on a scale of 1 - 10 (10 being highest)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you ever experienced trauma or abuse? (e.g. being physically hurt by, humiliated, or emotionally abused by another person)?

☐ Yes ☐ No

If you ever experienced trauma or abuse, would you like support (e.g. to talk with a counselor)?

☐ Yes ☐ No

How often in the past 3 months were you worried that your food would run out?

☐ Always ☐ Sometimes ☐ Rarely or Never

If completing for a child, does your child participate in any of the following?

☐ Family Centered Early Supports and Services ☐ Special Medical Services ☐ Partners in Health ☐ None

Are you pregnant?

☐ Yes ☐ No ☐ N/A

If yes, are there pregnancy complications (ex. diabetes, high blood pressure or multiples)?

☐ Yes ☐ No ☐ N/A

Have alcohol, prescription drugs or other substances been used during the pregnancy?

☐ Yes ☐ No ☐ N/A

Are you being treated for any of these Mental Health or Substance Use conditions?(Check all that apply)

☐ ADHD ☐ Autism ☐ Bipolar Disorder ☐ Depression ☐ Eating Disorder(anorexia, bulimia, other)

☐ Schizophrenia ☐ Serious Mental Illness ☐ Substance Use Problems ☐ None

Child Only ☐ Serious Emotional Disturbance

☐ Other

Do you drink alcoholic beverages?

☐ Yes ☐ No ☐ Choose not to answer

If yes, has anyone told you that your alcohol use is a problem?

☐ Yes ☐ No ☐ Choose not to answer

Do you feel that you need help with drug or alcohol use?

☐ Yes ☐ No ☐ Choose not to answer

Are you currently using street drugs (such as heroin, cocaine) or other drugs other than as prescribed?

☐ Yes ☐ No ☐ Choose not to answer

Have you had an overdose in the past 12 months?

☐ Yes ☐ No

Do you smoke cigarettes, use smokeless tobacco, or vape?

☐ Yes ☐ No ☐ Choose not to answer

Would you like to speak to someone about quitting?

☐ Yes ☐ No

Over the past 2 weeks, how often have you had little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Would you like to speak with someone about Mental Health/Substance use services?

☐ Yes ☐ No

Do you have difficulty doing the following activities by yourself? Check all that apply.

☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Using the toiliet

☐ Getting in and out chair ☐ Preparing meals ☐ Managing Money ☐ Taking medication as prescribed

☐ Performing home chores ☐ Grocery Shopping ☐ Not applicable due to member's age

Have you used the emergency room 3 times or more in the last 3 months?

☐ Yes ☐ No

Have you been hospitalized for more than a 2-week period in the last 3 months?

☐ Yes ☐ No

If yes, was it for a new baby in the NICU (neonatal intensive care unit)?

☐ Yes ☐ No

Have you made a suicide attempt in the past 12 months?

☐ Yes ☐ No

Have you been released from jail or prison in the last 6 months?

☐ Yes ☐ No ☐ Choose not to answer

Would you like a care manager to reach out to you to assist you with health concerns, community resources or other questions or issues?

☐ Yes ☐ No

Thank you for taking the time to answer these questions. Is there anything else you think we should know about you, your child, or family?

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Primary Care Physician (PCP) Form

Member Information

*Required Field

First Name: MI: Last Name:

Medicaid ID*: Date of Birth (mmddyyyy):

SSN: Telephone number:

Mailing Address:

City: State: Zip Code:

PCP Change Request - Please provide PCP Information

Requested PCP Name NPI#

Office Address:

City: State: Zip Code:

Office Phone: Effective Date (mmddyyyy):

The effective date will be based upon the plan's selection/change policy.

Reason for Change from Assigned PCP - Choose all that apply. Select at least one.

- ☐ New Member - made 1st time selection
- ☐ Already patient with requested PCP
- ☐ Requested PCP already sees family member
- ☐ Member Preference
- ☐ Member Moved
- ☐ PCP Hours didn't fit member need
- ☐ Quality of Care
- ☐ Provider Left Network
- ☐ Provider Location
- ☐ Association with hospital or medical group
- ☐ Language/communication barriers
- ☐ Wait time in provider office
- ☐ Availability to get appointment. Access to care
- ☐ Established relationship w/another
- ☐ Provider Request to Disenroll Member
- ☐ Other

_____

Signature of Member or Authorized Representative

Date (mmddyyyy)

_____

Print Name of Member or Authorized Representative

Directions: Please fax Member Change Data forms, with a copy of the member ID card, if available, to NH Healthy Families Member Services Department at 1-877-502-7255 or mail it to **NH Healthy Families Member Services**, 2 Executive Park Drive, Bedford, NH 03110. **If you have questions about how to complete this form or want to make this request** over the phone, please call the NH Healthy Families Member Services Department, Monday - Wednesday, 8 a.m. to 8 p.m. (EST), Thursday and Friday, 8 a.m. to 5 p.m. at **(866) 769-3085 (TDD/TTY (855) 742-0123).**

1-877-502-7255
2 Executive Park Drive, Bedford, NH 03110
over the phone, please call the NH Healthy Families Member Services Department, from 8 a.m. to 5 p.m. (EST), Monday through

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nh healthy families

Pregnancy Form

This form is confidential. If you have any problems or questions, please call **1-866-769-3085** (TDD/TTY 1-855-742-0123).

Are You Pregnant?* Yes ☐ No ☐ If you are pregnant, please continue to answer all the questions. Return the form in the envelope provided. We may call you if we find that you are at risk for problems with your pregnancy.

***Required Field**

Medicaid ID #:* Today's Date: (mmddyyyy)

Your First Name:* Your Birth Date:* (mmddyyyy)

Your Last Name:*

Mailing Address:

City: State: Zip Code:

Home Phone: - - Cell Phone: - -

Would you like to receive text messages about pregnancy and newborn care? Yes ☐ No ☐
If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe.

Email Address:

Your OB Provider's Name:

Your Due Date*: (mmddyyyy)

Primary insurance (for mom or baby) other than Medicaid? Yes ☐ No ☐

Race/Ethnicity (place a thick X in each box that applies) White ☐ Black/African American ☐

Hispanic/Latina ☐ American Indian/Native American ☐ Asian ☐ Hawaiian/Pacific Islander ☐

Other ☐ If other ethnicity, please specify

Preferred Language (if other than English)

Planning to breastfeed? Yes ☐ No ☐ If no, what is the reason?

Pediatrician chosen? Yes ☐ No ☐ Pediatrician Name

Number of Full Term Deliveries Number of Miscarriages Height ' "

Number of Preterm Deliveries Number of Stillbirths Pre-Pregnancy Weight

Do you have any of the following?* Yes ☐ No ☐ If yes, place a thick X in each box that applies.

Your Medical History

Previous preterm delivery (<37 weeks)? ☐
(A delivery more than three weeks early.)

Recent delivery within past 12 months? ☐

Was delivery within past 6 months? ☐

Previous C-Section? ☐

Current Pregnancy History

Preterm labor this pregnancy? ☐

Current gestational diabetes? ☐

Current twins? ☐

Current triplets? ☐

Currently having severe morning sickness? ☐

RETURN IN BLUE ENVELOPE

Your First Name:*

Your Birth Date:* (mmddyyyy)

Your Last Name:*

Diabetes (prior to pregnancy)?

Sickle Cell?

Asthma?

If yes, are asthma symptoms worse during pregnancy?

High Blood Pressure (prior to pregnancy)?

Previous neonatal death or stillborn?

HIV positive? HIV negative? Testing refused?

AIDS?

Thyroid problems?

Seizure disorder?

Seizure within the last 6 months?

Previous alcohol or drug abuse?

Current mental health concerns?

List:

Current STD? List

Current tobacco use? Amount

If yes, are you interested in quitting smoking?

Current alcohol use? Amount

Current street drug use?

Taking any prescription drugs (other than prenatal vitamins?) List

Any hospital stays this pregnancy?

Do you have enough food? Yes No

Do you lack reliable phone access? Yes No

Are you enrolled in WIC? Yes No

Are you homeless or living in a shelter? Yes No

Do you have problems getting to your doctor visits? Yes No

Do you feel unsafe in your home? Yes No

Please list any other social needs you may have:

Please list anything else you would like to tell us about your health:

RETURN IN GREEN ENVELOPE

Ready for My Recovery Form

This form is confidential.

STOP **Before submitting this form, you must complete your Health Risk Assessment Screening on page 1 or online at NHhealthyfamilies.com in order to be eligible for the Ready for My Recovery rewards** program. Submit your completed form and receive a My Recovery Journey backpack** filled with items and resources to support you in your recovery from substance misuse.**

Member Information

***Required Field**

Today's Date: (mmddyyyy)

Your First Name:* Your Birth Date:* (mmddyyyy)

Your Last Name:*

Mailing Address:

City: State: Zip Code:

Home Phone: - - Cell Phone: - -

Email:

Best day/time to reach you? _____

Have you recently used substances but are ready to take the first step in your recovery? Yes No

If you need immediate assistance with substance use, please call 2-1-1.

Complete this form and mail to:
NH Healthy Families, 2 Executive Park Drive, Bedford, NH 03110-9983

***Note:** Tobacco/nicotine use are not included as part of this program.*

**Some restrictions and limitations apply. Each member can earn up to $250 in cash and non-cash goods and services through June 30 each year.

19-0006-R3

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nh healthy families
2 Executive Park Drive
Bedford, NH 03110

Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow NH Healthy Families to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your services and benefits with NH Healthy Families will not change if you do not submit this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services at the phone number on the back of your member ID card.
- NH Healthy Families cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- If you need help, contact Member Services at the phone number on the back of your member ID card.
- Fill in all the information on this form. When finished, mail the form and any supporting documentation to

NH Healthy Families
ATTN: Compliance Department
2 Executive Park Drive
Bedford, NH 03110

Aviso al (la) afiliado(a):

- Al llenar este formulario, usted autoriza a NH Healthy Families a (i) que use su información de salud para un fin en particular, y/o (ii) que la dé a conocer a la persona o entidad que usted identifique en este formulario.
- Usted no tiene que firmar este formulario ni dar permiso a usar o dar a conocer su información de salud. Sus servicios y beneficios de NH Healthy Families no cambiarán si usted no firma este formulario.
- Si desea cancelar este formulario de autorización, envíenos por escrito una solicitud para revocarlo a la dirección que aparece al final de esta página. Servicios para los afiliados puede proporcionarle un formulario de revocación si les llama al número telefónico que se encuentra en la parte trasera de su tarjeta de identificación de afiliación.
- NH Healthy Families no puede prometer que la persona o el grupo al que nos permita dar a conocer su información de salud no la dará a conocer a alguien más.
- Conserve una copia de todos los formularios llenos que nos envíe. Si las necesita, podemos enviarle copias.
- Si necesita ayuda, comuníquese con Servicios para los afiliados al número telefónico que aparece en la parte trasera de su tarjeta de identificación de afiliación.
- Llene toda la información en este formulario. Al terminar, envíe el formulario y todos los documentos de apoyo a

NH Healthy Families
ATTN: Compliance Department
2 Executive Park Drive
Bedford, NH 03110

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nh healthy families
2 Executive Park Drive
Bedford, NH 03110

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

1

MEMBER INFORMATION:

Member Name *(print)*: _____

Member Date of Birth: _____ Member ID Number: _____

2 **I GIVE NH HEALTHY FAMILIES PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS** *(check one option below)*:

☐ to allow NH Healthy Families to help me with my benefits and services, **OR**

☐ to permit NH Healthy Families to use or share my health information for _____

3 **PERSON OR GROUP TO RECEIVE INFORMATION** *(add more Persons or Groups on next page)*:

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ -_____

4 **I AUTHORIZE NH HEALTHY FAMILIES TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION**
(NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information. ***Both CANNOT be selected.****)*

☐ **All of my health information INCLUDING:**
Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed);

OR

☐ **All of my health information EXCEPT** *(check only the boxes below that apply)*:

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

5 **THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:** _____
Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.

RETURN IN GREEN ENVELOPE

nh healthy families
2 Executive Park Drive
Bedford, NH 03110

6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:** _____

DATE: _____

IF LEGAL REPRESENTATIVE - Relationship to Member: _____

If you are the Member's legal or personal representative, ***you must send us copies of relevant forms****, such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO
NH Healthy Families, ATTN: COMPLIANCE DEPARTMENT
2 Executive Park Drive, Bedford, NH 03110

RETURN IN GREEN ENVELOPE

nh healthy families
2 Executive Park Drive
Bedford, NH 03110

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO RECEIVE INFORMATION:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: (   )   -

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: (   )   -

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: (   )   -

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: (   )   -

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: (   )   -

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: (   )   -

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: (   )   -

RETURN IN GREEN ENVELOPE

Revocation of Authorization to Use and/or Disclose Health Information

I want to cancel, or revoke, the permission I gave to NH Healthy Families to use my health information for a particular purpose or to share my health information with a person or group:

PERSON OR GROUP THAT RECEIVED THE INFORMATION:

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) ____ - _____

Authorization Signed Date (if known): / _____/_____

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ / _____/ _____ Member ID Number: _____

I understand that my health information (including, where applicable, my substance use disorder records) may have already been used or shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to use my health information for a particular purpose or to share my health information with the person or group. It does not cancel any other authorization forms I signed for health information to be used for another purpose or shared with another person or group.

Member Signature: _____ Date: _____ / _____/ _____

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

NH Healthy Families will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

NH Healthy Families
2 Executive Park Drive
Bedford, NH 03110
1-866-769-3085 (TDD/TTY 1-855-742-0123)
www.NHhealthyfamilies.com

Statement of Non-Discrimination

NH Healthy Families complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

NH Healthy Families cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

NH Healthy Families respecte toutes les lois fédérales en vigueur en matière de droits civils et ne se livre à aucune discrimination fondée sur la race, la couleur, l'origine nationale, l'âge, la situation de handicap ou le sexe.

ATTENTION: If you do not speak English, language assistance services are available to you at no cost. Call 1-866-769-3085 (TTY 1-855-742-0123).

ATENCIÓN: si no habla inglés, hay servicios de asistencia en diferentes idiomas disponibles para usted sin costo. Llame al 1-866-769-3085 (TTY 1-855-742-0123).

ATTENTION : si vous ne parlez pas anglais, des services d'aide linguistique sont mis à votre disposition sans paiement de votre part. Composez le 1-866-769-3085 (TTY 1-855-742-0123).