nh healthy families™

Get Started!

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.

If you do not have Internet access:

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

Member Checklist

- ☐ Detach Member ID Cards and store in a convenient place
- ☐ Set up your **Member Account** at **NHhealthyfamilies.com**
- ☐ Complete your **Health Risk Assessment Screening** online or using the enclosed form ***within the first 30 days of enrollment and receive $30 in*** myhealthpays™* ***rewards***
- ☐ **Find a Primary Care Physician (PCP)** online or using the enclosed form and make a wellness appointment with your PCP
- ☐ **Complete your Authorization to Use and Disclose Health Information** online or using the enclosed form
- ☐ If you are pregnant, complete your **Notice of Pregnancy (NOP)** online or using the enclosed form within your first trimester ***and receive $50 in*** myhealthpays™* ***rewards***
- ☐ If you would like help with substance misuse, complete your **Ready for My Recovery** online or using the enclosed form ***and receive a My Recovery Journey backpack****

  Members must submit their Health Risk Assessment Screening prior to submitting the Ready for My Recovery form.

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

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

19-0003

What's inside this booklet?

Prescription Medications

If you are currently taking prescription medication, it may require a prior authorization from NH Healthy Families before your next refill. Call your PCP or NH Healthy Families Member Services to find out if your medicine is one that does require authorization. You can also check the Preferred Drug List on the NH Healthy Families website, **NHhealthyfamilies.com** under Benefits and Services/Pharmacy.

Family and Friends Transportation

If a family member or friend provides transportation for you to an appointment, you can receive mileage reimbursement for that trip. To be eligible to receive this benefit, call Coordinated Transportation Services (CTS). Tell CTS the date and time of your appointment. Print a copy of the Reimbursement Form from **NHhealthyfamilies.com** under Member Resources/Member Handbook and Forms before your appointment. Bring it with you. Complete the first half of the form yourself and ask your provider to complete it. Remember to make a copy of any receipts you may have received. For more information or instructions on how to submit your form, contact CTS at **1-877-671-6291**.

Please Note: *Interpretation services are provided at no cost to you. This includes American Sign Language and real-time oral interpretation. We can also provide Auxiliary Aids and services or materials in other formats such as Braille, CD or large print. If you need something translated into a language other than English, please call us at* ***1-866-769-3085 (TDD/TTY: 1-855-742-0123)****. If you need an interpreter for your medical appointment, contact us 48 hours before your appointment.*

Set Up Your Online Member Account

JUST FOLLOW THE STEPS BELOW TO CREATE YOUR ACCOUNT:

STEP 1: Go Online

Go to NHhealthyfamilies.com

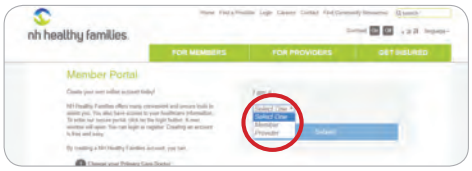
Two ways to begin:

- Click on **"Login"** at the top of the page.

Or

- Click on **"For Members"**
- Select **"Medicaid"** in the drop down
- Click on **"Secure Portal Login"** in the left tool bar.

- Under **"I am a:"** select **"Member"**

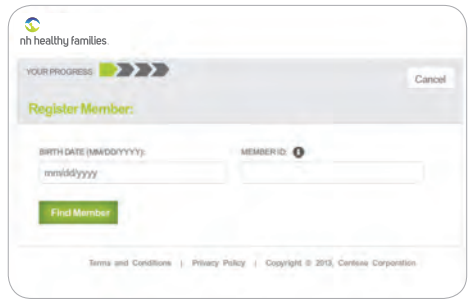


- Under **"My Plan is:"** select **"Medicaid"**

- Hit **Submit** button. This will take the member to the portal login page.
- Click on **"Sign Up Now"** button.

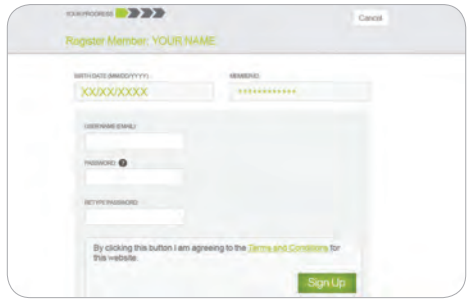
STEP 2: Enter Your Information

Fill in your birthdate and member ID number (on your ID card). Then click **Find Member.**

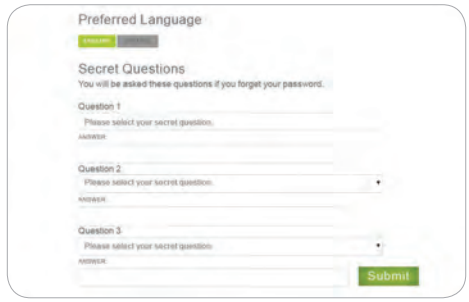


Choose your **preferred language** and fill in answers to your **secret questions.** If you forget your password, these secret questions can help you access your account. Click the **Submit** button.

STEP 3: Register Your Account



STEP 4: Verify Your Account



Download our Mobile App starting September 2019

Your Benefits at a Glance

NH Healthy Families offers:

INTEGRATED, COMPREHENSIVE MEDICAID BENEFITS

NH Healthy Families covers all NH Medicaid medical, behavioral health, pharmaceutical and preventive care services. Included in our coverage you will find:

Integrated Care Management Program
Local medical and behavioral health care managers working together for you

Preventive Care Coverage
Screenings, vaccinations, check-ups, well-child visits

Member Services
For help with understanding benefits, finding a provider, local resources, plan an appointment and find transportation for you

Health Coaches
For help with chronic ongoing conditions like asthma, diabetes and more

24/7 Nurse Advice Line
An extension of our team who will answer questions or give you advice when you aren't sure what to do

Transportation
Mileage reimbursed or rides available for covered care and services

HEALTH EXTRAS AT NO COST TO YOU!

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

myhealthpays™* Rewards Program
Earn money for healthy behaviors. You choose how to spend your rewards

MemberConnections®
At-home outreach to help you with your medical and social service needs

ConnectionsPLUS®*
Complimentary cell phones for those who need them

Start Smart for Your Baby®
Pregnancy program for education, support, and myhealthpays™* rewards

Healthy Kids Club Program
Educational program with fun activities for members 12 and under

Cigarettes, Smokeless Tobacco or Vaping Cessation Program
Help to quit using cigarettes, e-cigarettes or vaping

Expanded Transportation*
We'll take you to social services appointments like Alcoholics Anonymous and Narcotics Anonymous meetings

Ready for My Recovery
Care Management education and myhealthpays™* rewards for achieving milestones in your recovery from substance misuse

GATEWAY SERVICES

NH Healthy Families cares about our community. Gateway Services provides social supports to members and communities AT NO COST.

Foster Care Comfort-To-Go
Durable duffle bags with personal items for youth transitioning to Foster Care

No One Eats Alone™
Student-led initiative to increase awareness and address social isolation in schools

Self-Care Kits
Essential grooming items in a convenient carrying case for those who need them

Vision Van
Bringing vision screenings, prescription glasses and readers to communities throughout the state

myhealthpays™

It's easy to earn myhealthpays™* reward dollars.

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

Complete your Health Risk Assessment Screening online or on page 7 of this packet within 30 days of enrollment and earn $30 on your myhealthpays™ account.*

We will mail your myhealthpays™* Visa® Prepaid Card to you upon enrollment. You can keep earning myhealthpays™* rewards by completing more healthy activities. Your rewards will be added to your card once we are notified.

After you complete a healthy activity, we will add the reward dollars you have earned directly to your myhealthpays™* Visa® Prepaid Card.

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

FOR CHILDREN/YOUNG ADULTS		FOR WOMEN		FOR MEN	
Health Risk Assessment Screening Completion	**(Up to $30 per year)**	Health Risk Assessment Screening Completion	**(Up to $30 per year)**	Health Risk Assessment Screening Completion	**(Up to $30 per year)**
Well Baby Visits (15 months or Younger)	**($20 for 6 visits)**	Well Visit	**($20 per year)**	Well Visit	**($20 per year)**
Well Child Visits (24 months-21 years)	**($20 per year)**	Flu Vaccine	**($20 per year)**	Flu Vaccine	**($20 per year)**
ADHD follow-up	**($30)**	Breast Cancer Screening (Ages 40-74)	**($20 per year)**	Prostate Exam (Ages 50 and up)	**($20 per year)**
Flu Vaccine	**($20 per year)**	Cervical Cancer Screening (Ages 18-65)	**($20)**	Diabetes Care (Ages 18-75)	**($30)**
Additional, for Young Adults:		Diabetes Care (Ages 18-75)	**($30)**	Cigarettes, Smoke-less Tobacco or Vaping Cessation (Ages 12 and up)	**($20)**
Cigarettes, Smoke-less Tobacco or Vaping Cessation (Ages 12 and up)	**($20)**	Cigarettes, Smoke-less Tobacco or Vaping Cessation (Ages 12 and up)	**($20)**	Ready for My Recovery Program (Ages 12 and up)	**(Up to $115 in first year)**
Ready for My Recovery Program (Ages 12 and up)	**(Up to $115 in first year)**	Ready for My Recovery Program (Ages 12 and up)	**(Up to $115 in first year)**		
		Pregnant and New Mothers	**(Up to $150 See page 4)**		

USE YOUR myhealthpays™* REWARDS TO HELP PAY FOR:

- Utilities
- Transportation
- Telecommunications - Cell Phone Bill
- Childcare Services
- Education
- Rent
- Expenses for Dental, Chiropractic and Other Medical Services

OR, YOU CAN USE THEM TO:

- Shop at Walmart for everyday items**

**This card may not be used to buy alcohol, tobacco, or firearms products.

This 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. See Cardholder Agreement for complete usage restrictions.

Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.

Start Smart for Your Baby®

Take Care of Yourself and Your Baby

Our Start Smart for Your Baby® program provides customized support and care for pregnant women and new moms. This program helps you focus on your health during your pregnancy and your baby's first year.

Complete your Notice of Pregnancy (NOP) online or on page 13 within your first 12 weeks and earn $50 on your myhealthpays™* account PLUS a Diaper Bag filled with essential baby items, including diapers. Complete your NOP within 13-24 weeks and earn $25 PLUS the Diaper Bag.**

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

START SMART FOR YOUR BABY® OFFERS THESE BENEFITS AT NO COST TO YOU:

CARE MANAGEMENT	EDUCATION AND SUPPORTS
• Medical staff to work with you and your doctor if you experience any issues during your pregnancy • Prenatal vitamins • Information about pregnancy and newborn care • Community help with housing, food, clothing and cribs • Breastfeeding support and resources	• Postpartum resources • Smoking, e-cigarette and vaping cessation • Substance Use Disorder support • Baby shower events • Text and email health tips for you and your newborn

myhealthpays™*

PREGNANT AND NEW MOMS CAN EARN UP TO $210 IN REWARDS AND EXTRAS

Just for healthy behaviors!

1st Trimester — **$50** — **Notice of Pregnancy (NOP)*****

OR

2nd Trimester — **$25** — **Notice of Pregnancy (NOP)*****

→ **Up to $60** — **Prenatal Care Visits ($20 for every third visit)**

→ **Birth**

→ **Postpartum** — **$20** — **Postpartum Visits**

AND

Infant Wellness Visits — **$20** — **For 6 Visits**

Your infant will receive a My Health Pays™ reward that can be used on baby items.

Just for completing your Notice of Pregnancy (NOP), you'll receive a diaper bag** filled with essential baby items, including: diapers, baby wipes, baby bath, hand sanitizer, zinc paste and bath towel.

**The Diaper Bag ($60 cash value) filled with baby essentials is available only for members who submit their Notice of Pregnancy within the first 26 weeks of their pregnancy.

***Pregnant members must complete and submit their Notice of Pregnancy form within 12 weeks of their pregnancy to be eligible for the $50 reward. Members who submit their Notice of Pregnancy within 26 weeks of their pregnancy can still earn a $25 reward.

"I am just writing to say THANK YOU! I informed you guys of my pregnancy, and this huge hospital bag filled with diapers, wipes, and all the necessities, was just sent to me! What a wonderful surprise!..."

– NH Healthy Families member

Find your NOP form on page 13 or online at NHhealthyfamilies.com under Member Resources/Member Handbook and Forms.

Guide to Forms

- 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**.
- Please return the forms to the following addresses:

FORM	SEND TO
• ***Health Risk Assessment Screening*** • ***Notification of Pregnancy (NOP)***	Medical Management Notifications PO Box 2010 Farmington, MO 63640-9706
• ***Primary Care Physician (PCP)*** • ***Ready for My Recovery*** • ***Authorization to Use and Disclose Health Information***	NH Healthy Families 2 Executive Park Drive Bedford, NH 03110-9983

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

Health Risk Assessment Screening

This form will help us determine if there are any extra services or tools you may need. Complete your Health Risk Assessment Screening within the first 30 days of enrollment and ***earn $30*** on your myhealthpays™* account. If you need help completing your Health Risk Assessment Screening, call Member Services at **1-866-769-3085**.

Primary Care Physician (PCP)

NH Healthy Families offers you the choice of one primary care provider (PCP) to help you maintain your health. Your PCP can be a doctor, a nurse practitioner, or a physician's assistant. It is easy to choose a PCP. We have a lot of providers to choose from. You should visit your PCP within 90 days of enrollment with NH Healthy Families. If you need help finding a PCP near you, Visit **NHhealthyfamilies.com**, or call Member Services at **1-866-769-3085**.

Notification of Pregnancy (NOP)

If you are pregnant, you are eligible for a number of our programs for expecting women. We want to make sure you get the health coverage you need throughout your pregnancy and the birth of your baby. Before we can help, we need to know you are pregnant. Complete your Notice of Pregnancy form within your first 12-weeks of pregnancy and ***earn $50*** on your myhealthpays™* account. Complete your Notice of Pregnancy form between 12-weeks and 26-weeks and ***earn $25*** on your myhealthpays™* account. You'll also receive a diaper bag** filled with baby essentials for completing your form within 26-weeks of your pregnancy.

Ready for My Recovery

If you would like to begin a program of recovery for substance misuse, we want to help. Members who submit their Health Risk Assessment Screening can complete the Ready for My Recovery form and be contacted by a Care Manager: our Care Managers will connect you with the appropriate help based on your needs. Members with substance misuse who complete the Ready for My Recovery form will ***receive a My Recovery Journey backpack**** filled with items and resources to support their recovery. myhealthpays™* rewards are offered to members who engage in continuous recovery from substance misuse.

Note: *Alcohol use and tobacco/nicotine use are not included as part* of this program.

Authorization to Use and Disclose Health Information

Completing this is voluntary and will not affect your coverage if you decide not to sign it. Completing this will allow NH Healthy Families to share your health information with the individual or entity that you identify. It can be canceled at any time. Please read the form carefully for information.

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

**The Diaper Bag ($60 cash value) filled with baby essentials is available only for members who submit their Notice of Pregnancy within the first 26 weeks of their pregnancy.

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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)

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

☐ 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

nh healthy families

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 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).

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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).*

nh healthy families™

Are You Pregnant?* Yes ☐ No ☐ If you are pregnant, please continue to answer all the questions.
Return the form in the envelope provided. When your answers are received, a gift will be mailed to you!
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? ☐

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:

Ready for My Recovery Form

This form is confidential.

nh healthy families

STOP **Before submitting this form, you must complete your Health Risk Assessment Screening on page 7 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.**

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

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: *Alcohol use and tobacco/nicotine use are not included as part* of this program.

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Authorization to Use and Disclose Health Information

nh healthy families

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 sign this form or give permission to use or share your health information. Your services and benefits with NH Healthy Families will not change if you do not sign 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.
- 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.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the first page.

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth:_____Member ID Number: _____

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:

- ☐ to allow NH Healthy Families to help me with my benefits and services
- ☐ to permit NH Healthy Families to use or share my health information for_____. Or
- ☐ to allow NH Healthy Families to make changes (examples: update PCP, update demographics including address and phone and update COB)

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): _____

Address:_____

City:_____State:_____Zip:_____Phone: ( ) -_____

I AUTHORIZE NH Healthy Families TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

☐ **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 all boxes 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: _____

Authorization End Date: _____/_____/_____*(date the authorization ends unless cancelled)*

Member Signature:_____**Date:**_____/_____/_____

(Member or Legal Representative Sign Here)

Relationship to Member: _____

If you are the Member's personal representative, please send us copies of those forms (such as power of attorney or order of guardianship).

Mail to: NH Healthy Families 2 Executive Park Dr Bedford, NH 03110 Toll Free: 1-866-769-3085
(TDD/TYY) 1-855-742-0123 Fax: 1-877-502-7255

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) 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: (   )   -

Name (individual or entity): ____________________

Address: ____________________

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

Statement of Non-Discrimination

NH Healthy Families complies with applicable Federal and State civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NH Healthy Families does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, or sexual orientation. NH Healthy Families prohibits discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

NH Healthy Families:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact NH Healthy Families at 1-866-769-3085 (TDD/TTY 1-855-742-0123.)

NH Healthy Families prohibits discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. If you believe that NH Healthy Families has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievances and Appeals Coordinator, NH Healthy Families, 2 Executive Park Drive, Bedford, NH 03110 Toll Free: 1-866-769-3085 (TDD/TTY 1-855-742-0123.) Fax 1-866-270-9943.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, NH Healthy Families is available to help you. You may also file a discrimination complaint through the DHHS Office of the Ombudsman who has been designated to coordinate the efforts of NH DHHS's civil rights compliance for the Department: State of New Hampshire, Department of Health and Human Services, Office of the Ombudsman, 129 Pleasant Street, Concord, NH 03301-3857; (603) 271-6941 or (800) 852-3345 ext. 6941, FAX (603) 271-4632 TDD Access: relay NH 1-800-735-2964; E-mail: ombudsman@dhhs.nh.gov.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, Complaint forms are available at https://www.ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TDD 800-537-7697.

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