Get Started!

**If you have Internet access:**
- Go online to [NHhealthyfamilies.com](http://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](http://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.
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
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.

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

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.

USE YOUR myhealthpays™ REWARDS TO HELP PAY FOR:
- Utilities
- Telecommunications - Cell Phone Bill
- 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.

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

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

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.

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

Just for healthy behaviors!

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

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

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

Postpartum
$20 Infant Wellness Visits

Birth

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

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

• 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.**
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.

**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)

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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

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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 toilet  [ ] 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?
Primary Care Physician (PCP) Form

Member Information

First Name: ___________________________ MI: ___________________________
Medicaid ID*: ___________________________
SSN: ___________________________
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 Request to Disenroll Member
☐ 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).

2019 NH Healthy Families is underwritten by Granite State Health Plan, Inc.
**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. 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? [ ]

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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

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

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.
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 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 membership 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 tests; 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).

ALL_18_7367FORM_06142019 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: (______) __________

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.