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

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.

*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.

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.

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. Complete within 31-90 days and earn $15.

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

NHhealthyfamilies.com

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

**Health Risk Assessment Screening** ............................................. 1
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® Visa® Prepaid Card**. Complete your HRA between 31 and 90 days and earn $15*. If you need help completing the form, call us at 1-866-769-3085.

**Did you know you also have 2 more ways to complete your HRA?**

**WALMART PHARMACY KIOSK**
Scan the QR code on the back of your myhealthpays® Visa® Prepaid Card** at the kiosk. Next, Choose Health Needs Screening under the list of Current Programs and answer the questions about your health. Your rewards will be immediately loaded to your card once you’re done!

**NH HEALTHY FAMILIES MOBILE APP**
You will find the HRA feature under the menu icon (3 horizontal bars)

**Primary Care Physician (PCP)** ............................................. 5
NH Healthy Families offers you the choice of one primary care physician (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)** ............................................. 7
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 $100* on your myhealthpays® Visa® Prepaid Card**. Complete your Notice of Pregnancy form between 12-weeks and 26-weeks and earn $50*.

**Ready for My Recovery** ............................................................. 9
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 to connect you with the appropriate help. 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: Tobacco/nicotine use are not included as part of this program.

**Authorization to Use and Disclose Health Information** .............. 11
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.

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*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.
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.

**Health Risk Assessment Screening**

**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)

© 2020 NH Healthy Families. All rights reserved.
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 on IV antibiotics for more than 3 weeks?  
☐ 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?
<table>
<thead>
<tr>
<th>Member Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>MI:</td>
<td>Last Name:</td>
</tr>
<tr>
<td>Medicaid ID*:</td>
<td>Date of Birth (mmddyyyy):</td>
<td></td>
</tr>
<tr>
<td>SSN:</td>
<td>Telephone number:</td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City: State: Zip Code:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PCP Change Request - Please provide PCP Information**

<table>
<thead>
<tr>
<th>Requested PCP Name</th>
<th>NPI#</th>
<th>Office Address:</th>
<th>City: State: Zip Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**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
- 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 over the phone, please call the NH Healthy Families Member Services Department, from 8 a.m. to 5 p.m. (EST), Monday through 1-877-502-7255
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).
Primary Care Physician (PCP) Form

Member Information

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).

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? [ ]

- Preterm labor this pregnancy? [ ]

- Current gestational diabetes? [ ]

- Current twins? [ ]

- Current triplets? [ ]

- Currently having severe morning sickness? [ ]

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<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Diabetes (prior to pregnancy)?</td>
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<tr>
<td>Sickle Cell?</td>
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<tr>
<td>Asthma?</td>
<td></td>
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<tr>
<td>If yes, are asthma symptoms worse during pregnancy?</td>
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<td></td>
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<tr>
<td>High Blood Pressure (prior to pregnancy)?</td>
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<tr>
<td>Previous neonatal death or stillborn?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV positive?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>HIV negative?</td>
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<td></td>
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<tr>
<td>Testing refused?</td>
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<tr>
<td>AIDS?</td>
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<td></td>
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<tr>
<td>Thyroid problems?</td>
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<td></td>
<td></td>
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<tr>
<td>Seizure disorder?</td>
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<tr>
<td>Seizure within the last 6 months?</td>
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<tr>
<td>Previous alcohol or drug abuse?</td>
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<td></td>
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<tr>
<td>Current mental health concerns?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>List:</td>
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<td></td>
<td></td>
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<tr>
<td>Current STD?</td>
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<td></td>
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<tr>
<td>List:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Current tobacco use?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Amount:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Current alcohol use?</td>
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<td></td>
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<tr>
<td>Amount:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current street drug use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking any prescription drugs (other than prenatal vitamins?)</td>
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<td></td>
<td></td>
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<tr>
<td>List:</td>
<td></td>
<td></td>
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<tr>
<td>Any hospital stays this pregnancy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have enough food?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you lack reliable phone access?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you enrolled in WIC?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you homeless or living in a shelter?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have problems getting to your doctor visits?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel unsafe in your home?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please list any other social needs you may have:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please list anything else you would like to tell us about your health:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Ready for My Recovery Form

This form is confidential.

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 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.
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
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._
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
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: ( ) _________

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City: ____________________ State: ___________ Zip: _______ Phone: ( ) _________

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City: ____________________ State: ___________ Zip: _______ Phone: ( ) _________

Name (individual or entity):
Address:
City: ____________________ State: ___________ Zip: _______ Phone: ( ) _________

Name (individual or entity):
Address:
City: ____________________ State: ___________ Zip: _______ Phone: ( ) _________
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
1-866-789-3085 (TDD/TTY 1-855-742-0123)
www.NHhealthyfamilies.com
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.