



UCare Connect (Special Needs BasicCare) Enrollment Form

UCare Connect Enrollment

612-676-3554 or 1-800-707-1711

TTY users call

612-676-6810 or 1-800-688-2534.

Monday – Friday, 8 am – 5 pm

The call is free.

UCare Connect Customer Service

612-676-3395 or 1-877-903-0061

TTY users call

612-676-6810 or 1-800-688-2534.

Monday – Friday, 8 am – 5 pm

The call is free.

You can speak to someone about getting
this information for free in other languages.

Call 1-800-203-7225.

TTY users call 1-800-688-2534,
Monday – Friday, 8 am – 5 pm The call is free.

Return the completed form, pages 2 to 4, to:

UCare

P.O. Box 52

Minneapolis, MN 55440

You can also fax this form to UCare at 612-884-2122

UCare Connect service area: Aitkin, Anoka, Becker, Benton, Blue Earth, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Cook, Cottonwood, Crow Wing, Dakota, Faribault, Fillmore, Freeborn, Hennepin, Houston, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnommen, Marshall, Martin, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Redwood, Rice, Rock, Roseau, Scott, Sherburne, St. Louis, Stearns, Swift, Todd, Wadena, Washington, Watonwan, Wilkin, Winona, Wright and Yellow Medicine.



UCARE CONNECT (SNBC) ENROLLMENT FORM

Office Use Only:

Last name		First name		MI (optional)	Birth date (____/____/____) MM DD YYYY	
County you live in			Phone number (____) _____ - _____		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Street address (where you live)			City		State	Zip code
Mailing address (if different from where you live)			City		State	Zip code
Email address (optional)						
Medical Assistance ID number (PMI)			Case number			
Do you need an interpreter? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, check one of the boxes below						
<input type="checkbox"/> Spanish (01) <input type="checkbox"/> Hmong (02) <input type="checkbox"/> Vietnamese (03) <input type="checkbox"/> Khmer Cambodian (04) <input type="checkbox"/> Lao (05) <input type="checkbox"/> Russian (06) <input type="checkbox"/> Somali (07) <input type="checkbox"/> ALS American Sign Language (08) <input type="checkbox"/> Amharic (09) <input type="checkbox"/> Arabic (10) <input type="checkbox"/> Oromo (12) <input type="checkbox"/> Burmese (14) <input type="checkbox"/> Cantonese (15) <input type="checkbox"/> French (16) <input type="checkbox"/> Korean (20) <input type="checkbox"/> Karen (21) <input type="checkbox"/> Other, explain (98) _____						
Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT) <input type="checkbox"/> YES <input type="checkbox"/> NO						
Do you live in a long-term care facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, fill in the information below: Name of facility: _____ Phone number: (____) _____ - _____						
Do you have Medicare coverage? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, complete the information below Medicare number: _____						
Hospital (Part A) Begin Date:			Medical (Part B) Begin Date:			
Do you have other medical coverage or private insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO						
If YES, insurance company name: _____						
Policy holder's name: _____			Group number: _____			
Policy/ID number: _____			_____			
Is this insurance through an employer? <input type="checkbox"/> YES <input type="checkbox"/> NO						

YOU ARE CHOOSING HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Remember, joining SNBC is voluntary. You can always request to change back to Medical Assistance fee-for-service effective the 1st of the next month.

Primary care clinic you are choosing	Primary care clinic (PCC) provider ID number found in the Provider and Pharmacy Directory
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Under UCare Connect, I understand that:

<p><i>UCare Connect</i> will be providing my health care covered by Medical Assistance.</p>
<p>Once I am a member of <i>UCare Connect</i>, I have the right to appeal any services that are being denied, reduced, or stopped, or if <i>UCare Connect</i> is denying payment for services.</p>
<p>I will be notified of the date my coverage will start.</p>
<p>On the date <i>UCare Connect</i> coverage begins, I must get my health care from <i>UCare Connect</i> doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get <i>UCare Connect</i> approval to see other providers in some circumstances.</p>
<p>I will read the Member Handbook I get from <i>UCare Connect</i>. It will have the rules I must follow and more information about the services my plan covers. Services contained in <i>UCare Connect's</i> Member Handbook will be covered.</p>
<p>Some services require authorization from <i>UCare Connect</i>. Without authorization, <i>UCare Connect</i> will not pay for these services.</p>
<p>My <i>UCare Connect</i> benefits cannot be canceled because I get sick or use health care services.</p>
<p>I can choose to leave <i>UCare Connect</i> and change back to Medical Assistance fee-for-service. The effective date depends upon the date your request is received. I understand that I will be enrolled in <i>UCare Connect</i> through the last day of the month.</p>
<p>My health care services will be coordinated through <i>UCare Connect</i>. I may have to choose a primary care clinic.</p>
<p>To be enrolled and stay enrolled in <i>UCare Connect</i>, I must:</p> <ul style="list-style-type: none">• Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT)• Be at least 18 years old and under 65 years old• Be eligible for Medical Assistance (Medicaid) without a medical spenddown• Either have no Medicare, OR have both Medicare Parts A and B• Live in a county serviced by <i>UCare Connect</i> <p>If this changes, I will notify my county worker and <i>UCare Connect</i> so my information can be updated.</p>
<p>If I get a medical spenddown while enrolled in SNBC and do not pay it to DHS, I will be disenrolled from <i>UCare Connect</i>.</p>
<p>If I am on Medical Assistance for Employed Persons with Disabilities (MA-EPD), you must continue to pay your MA-EPD premium to remain eligible for Medical Assistance.</p>

By enrolling in UCare Connect, I authorize:

The sharing of information about my Medical Assistance eligibility status and the information on this form among the state, its representatives, the county where I live and **UCare Connect**.

The information on this enrollment form is correct to the best of my knowledge.

I understand that my signature (or the signature of person authorized to act on my behalf under the laws of the state where I live) on this form means that I have read and understand the contents of the form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized by state law to complete this enrollment form on my behalf, and 2) documentation of this authority is available upon request by the state or UCare Connect.

Signature of enrollee or authorized representative:	Date:
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If you are the authorized representative, you must sign above and provide the following information

Name (print):	Relationship to enrollee:	Phone number:
Street address, City, State, Zip:		

Page 4 should be signed and filled out by you or your authorized representative.

When the form is complete, mail or fax pages 2 to 4 to **UCare Connect**. Our address and fax number is on the cover of this form.

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጎምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤတွဲရက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntauv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူၣ်ဟ်သးဘၣ်တက့ၢ်. ဝဲနမ့ၢ်လိၣ်ဘၣ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်,ကိးဘၣ်လီၤတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພີ, ຈົ່ງ ໂທໂປຣໂປຣໄພາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

UCare

Attn: Appeals and Grievances

PO Box 52

Minneapolis, MN 55440-0052

Toll Free: 1-800-203-7225

TTY: 1-800-688-2534

Fax: 612-884-2021

Email: cag@ucare.org

Auxiliary Aids and Services: UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services: UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office for Civil Rights
 U.S. Department of Health and Human Services
 Midwest Region
 233 N. Michigan Avenue, Suite 240
 Chicago, IL 60601
 Customer Response Center: Toll-free: 800-368-1019
 TDD Toll-free: 800-537-7697
 Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
 540 Fairview Avenue North, Suite 201
 St. Paul, MN 55104
 651-539-1100 (voice)
 800-657-3704 (toll-free)
 711 or 800-627-3529 (MN Relay)
 651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator

Minnesota Department of Human Services

Equal Opportunity and Access Division

P.O. Box 64997

St. Paul, MN 55164-0997

651-431-3040 (voice) or use your preferred relay service