UCare Connect + Medicare (HMO D-SNP) Enrollment Form

UCare Connect + Medicare Enrollment Telephone Numbers
Medical and Prescription Drug questions:

1-800-707-1711
TTY for the hearing impaired at 1-800-688-2534
8 am – 5 pm, Monday – Friday
The call is free.

UCare Connect + Medicare Customer Service Telephone Numbers

1-855-260-9707
TTY for the hearing impaired at 1-800-688-2534
8 am – 8 pm, seven days a week
The call is free.

Return the completed form, pages 2 to 6, to:

UCare
PO Box 52
Minneapolis, MN 55440
Fax: 612-884-2122

Please contact UCare Connect + Medicare Customer Service at the number listed above if you need information in another language or format.

UCare is an HMO D-SNP health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare depends on contract renewal.

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

H5937_7252_102025_C
U7252 (10/2025)

Member Name: _____ MHCP Member Number: _____

UCare Connect + Medicare (HMO D-SNP) Enrollment Request Form

To join UCare Connect + Medicare, you must have **Medicare Part A**, **Medicare Part B**, and **Medical Assistance without a medical spenddown**, **and** be at least 18 and under age 65, have a certified disability through the Social Security Administration or the State Medical Review Team, **and** live in UCare Connect + Medicare's service area. You must also be a United States citizen or be lawfully present in the U.S.

Section 1. Tell us about yourself:

<table>
<tr><td>1</td><td colspan="4">Name: (first, middle, last)</td></tr>
<tr><td>2</td><td colspan="2">Date of birth:</td><td colspan="2">Sex:</td></tr>
<tr><td>3</td><td colspan="4">Phone number:
(_____) _____ - _____</td></tr>
<tr><td rowspan="2">4</td><td colspan="4">Address where you live (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):</td></tr>
<tr><td>City:</td><td>State:</td><td>ZIP code:</td><td>County:</td></tr>
<tr><td rowspan="2">5</td><td colspan="4">Address where you get mail (if different from where you live):</td></tr>
<tr><td>City:</td><td>State:</td><td>ZIP code:</td><td>County:</td></tr>
<tr><td>6</td><td colspan="4">Do you live in a long-term care facility? If Yes, fill in the information below:
Name of the facility: Phone number:
(_____) _____ - _____</td></tr>
<tr><td>7</td><td colspan="4">Do you need an interpreter? □ Yes □ No If Yes, check the language below:
□ 01 Spanish □ 02 Hmong □ 03 Vietnamese □ 04 Khmer (Cambodian) □ 05 Lao □ 06 Russian
□ 07 Somali □ 08 ASL (American Sign Language) □ 09 Amharic □ 10 Arabic □ 12 Oromo □ 14 Burmese
□ 15 Cantonese □ 16 French □ 20 Korean □ 21 Karen □ 98 Other
_____</td></tr>
</table>

Member Name: _____ MHCP Member Number: _____

Section 2. Tell us more about yourself:

You are not required to answer questions or give any information in this section. It's your choice to share this information with us. We can't deny you coverage if you don't answer them.

8	**Do you want us to send you information in a language other than English?** □ **Yes** □ **No** If Yes, write language: _____
9	**Do you want us to send you information in an accessible format?** □ **Yes** □ **No** If Yes, check format below. □ Braille □Large print □ Audio CD □ Data CD Please contact UCare Connect + Medicare at 1-855-260-9707 if you need information in an accessible format other than what's listed above. Our office hours are 8 am – 8 pm, seven days a week. TTY users can call 1-800-688-2534.
10	**Do you want to get information by email?** □ **Yes** □ **No** If Yes, provide your email address below. Email: _____
11	**Do you work?** □ **Yes** □ **No** **Does your spouse work?** □ Yes □ No □ Does not apply
12	**Name of the primary care clinic/care system you are choosing:**

Section 3. Tell us about your Medicare and Medical Assistance coverage:

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) Member Number as it appears on the front of your card. This is also known as your Medical Assistance Member Number.

13	**Medicare Number:** _____	**MHCP Member Number:** _____

Section 4. Tell us about your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

14	**Do you have other health coverage?** □ **Yes** □ **No** If Yes, fill in the information below:	
15	**Name of your plan (and employer, if applicable):**	**Group number:**
		Policy or ID number:

Member Name: _____ MHCP Member Number: _____

16	**Are you leaving employer or union coverage?** □ **Yes** □ **No** If Yes, what is the coverage end date? _____

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join UCare Connect + Medicare. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

Section 5. Tell us about your enrollment eligibility.

17. Please read the following statements carefully and check the box if the statement applies to you. **Check all that apply**. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

□ I am applying during the Medicare Advantage plan annual enrollment period from October 15 through December 7 and want my enrollment effective January 1.

□ I am new to Medicare.

□ I have both Medicare and Medical Assistance (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

□ I have Medicare and get full Medical Assistance benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medical Assistance managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).

□ I recently had a change in my Medical Assistance (newly got Medical Assistance or had a change in level of Medical Assistance) on (date) _____.

□ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (date) _____.

□ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on (date) _____.

□ I recently moved outside of the service area for my current plan, or I recently moved and have new options available to me. I moved on (date) _____.

□ I am leaving employer or union coverage on (date) _____.

□ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

□ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (date) _____.

Member Name: _____ MHCP Member Number: _____

□ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

□ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (date) _____.

□ I recently was released from incarceration. I was released on (date) _____.

□ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date) _____.

□ I recently obtained lawful presence status in the United States. I got this status on (date) _____.

□ I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, State, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact UCare Connect + Medicare at 1-800-707-1711 (TTY users should call 1-800-688-2534) to find out if you're eligible to enroll. We are open 8 am – 5 pm, Monday – Friday.

Member Name: _____ MHCP Member Number: _____

Please read the information on page 7 and sign below.

When you sign this form, it means that you understand the information you read.

_____
Name of Applicant (Please print)

_____ _____
Signature Today's Date

If you are the authorized representative, **you must sign above** and provide the following information.

_____ _____
Name (Print) Relationship to Enrollee

_____ _____
Address (Print) Telephone Number

When the form is completed, mail or fax it to UCare Connect + Medicare. Our address and fax number are on the cover of this form.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

Member Name: _____ MHCP Member Number: _____

Information and Acknowledgement Statements

• My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. • I must keep Medicare Part A and Part B and Medical Assistance to stay in UCare Connect + Medicare. • I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans). • By joining UCare Connect + Medicare, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize collection of this information (refer to the Privacy Act Statement below). • I understand that when my UCare Connect + Medicare coverage begins, I must get my medical and prescription drug benefits from UCare Connect + Medicare. • Benefits and services provided by UCare Connect + Medicare and contained in my *Member Handbook* are covered. Neither Medicare nor UCare Connect + Medicare will pay for benefits or services that are not covered. • I understand that UCare Connect + Medicare doesn't usually cover people while they're out of the country except under limited circumstances.	• I can choose to leave UCare Connect + Medicare any month of the year. I understand my Medical Assistance will be provided fee-for-service. I understand I can re-enroll in the non-integrated SNBC plan I was enrolled in before UCare Connect + Medicare by filling out a new enrollment form. • If I get a medical spenddown while enrolled in UCare Connect + Medicare and do not pay it to the State, I will be disenrolled from UCare Connect + Medicare. • The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. • I understand that my signature (or my authorized representative's signature) on this form means that I've read and understand the contents of this form. If an authorized representative signs, this signature means that: 1) this person is authorized under State law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare and/or Medical Assistance.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Member Name: _____ MHCP Member Number: _____

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 612-676-3310 or 1-855-260-9707 (TTY users call 612-676-6810 or 1-800-688-2534), 8 am – 8 pm, seven days a week.

This plan is a dual-eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and Medical Assistance from a state plan under Medicaid.

Additional requirements are:

- You live in the UCare Connect + Medicare service area
- You have both Medicare Part A and Medicare Part B
- You are a United States citizen or are lawfully present in the United States
- You are at least age 18 and under age 65
- You have a certified disability

Understanding the Benefits

- ☐ The Member Handbook provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **ucare.org/formembers** or call 612-676-3310 or 1-855-260-9707 (TTY users call 612-676-6810 or 1-800-688-2534) to view a copy of the Member Handbook.
- ☐ Review the Provider and Pharmacy Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Provider and Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary (list of covered drugs) to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider and Pharmacy Directory).

NO ENGLISH  1-800-203-7225 612-676-3200

TRS: 711

ATTENTION: If you speak English, free language assistance services are available to you free of charge and without unnecessary delay. Additionally, appropriate auxiliary aids and services to provide information in accessible formats are available free of charge and in a timely manner. Please call the number above or speak to your provider. English

ማሳሰቢያ፦ አማርኛ ተናጋሪ ከሆኑ ፤ ነጻ የቋንቋ ድጋፍ አገልግሎቶች ካለምንም ክፍያ እና ካለአላስፈላጊ መዘግየት ማግኘት ይችላሉ። በተጨማሪም መረጃን በቀላሉ ለማግኘት በሚያስችል ቅርጸት ለማቅረብ ተገቢ የሆኑ የመስማት ድጋፍ እና አገልግሎቶች ከክፍያ ነጻ በሆነ እና ግዜውን በጠበቀ መልኩ ማግኘት ይችላሉ። እባክዎ ከላይ ባለው ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። Amharic

تنبيه: نقدم لمتحدثي اللغة العربية خدمات مساعدة لغوية مجانية وفورية، بالإضافة إلى وسائل وخدمات مساعدة مناسبة، وبصيغة معلومات سهلة بدون تكلفة وبشكل سريع. يرجى التواصل على الرقم الموضح أعلاه أو مراجعة مقدم الخدمة المباشرة. Arabic

သတိပြုရန် – အကယ်၍ သင်သည် မြန်မာဘာသာစကား ပြောဆိုသူဖြစ်လျှင် အခမဲ့ ဘာသာစကားဆိုင်ရာ ပံ့ပိုးထောက်ပံ့ပေးမှု ဝန်ဆောင်မှုများအား မလိုအပ်သည့် နှောင့်နှေးကြန့်ကြာမှုများ မရှိစေဘဲ သင် အခမဲ့ ရရှိနိုင်မည် ဖြစ်သည်။ ထို့ပြင် အချက်အလက်များအား အလွယ်တကူ ဝင်ရောက်ရယူနိုင်စေသော ဖောမတ်ပုံစံများဖြင့် ထောက်ပံ့ပေးထားသည့် သက်ဆိုင်ရာ ဖြည့်စွက် ထောက်ပံ့မှုများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့၊ အချိန်မ ရရှိနိုင်စေရန် စီမံပေးထားပါသည်။ ကျေးဇူးပြုပြီး အထက်ဖော်ပြပါ ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ သို့မဟုတ် သင်၏ ထောက်ပံ့သူဖြင့် ပြောဆိုဆွေးနွေးပါ။ မြန်မာဘာသာစကား Burmese

យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (ខ្មែរ) សេវាកម្មជំនួយភាសាឥតគិតថ្លៃមានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ និងដោយភ្ជាន់ការពន្យារពេលមិនចាំបាច់ឡើយ។ លើសពីនេះ ជំនួយ និងសេវាកម្មដែលសមស្របក្នុងការផ្តល់ព័ត៌មានក្នុង ទម្រង់ដែលអាចចូលប្រើបានគឺអាចរកបានដោយឥតគិតថ្លៃ និងទាន់ពេលវេលា។ សូមហៅទូរសព្ទទៅលេខខាងលើ ឬនិយាយជាមួយអ្នកផ្តល់សេវារបស់អ្នក។ ភាសាខ្មែរ (ខ្មែរ) Cambodian (Khmer)

注意：如果您說簡體中文，您可以免費獲得語言協助服務，且不會有不必要的延誤。此外，還能免費及時獲取以無障礙格式提供資訊的適當輔助工具和服務。請撥打上面的電話號碼，或與您的服務提供商溝通。 Cantonese (Traditional Chinese)

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, sans frais et sans délai. En outre, des aides et services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont disponibles gratuitement et rapidement. Veuillez appeler le numéro ci-dessus ou contacter votre fournisseur. French

CEEB TOOM: Yog koj hais lus Hmoob, muaj kev pab txhais lus dawb rau koj siv. Koj tsis tas them nqi thiab yuav tsis qeeb. Kuj muaj cuab yeej thiab kev pab los pab koj nyeem cov ntaub ntawv kom yooj yim nkag siab. Koj hu tau rau tus xov tooj saum toj no lossis nrog koj tus kws kho mob tham. Hmong

NO ENGLISH  1-800-203-7225 612-676-3200

TRS: 711

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤကညီကျိာ်အယိ, နမၤနှ့် ကျိာ်တၢ်ဆီဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤ ဒီးတအိဉ်ဒီး တၢ်မၤယံာ်မၤနီၣ်သးဘဉ်နၵ်လီၤ. အါနှ့်အနၵ်, တၢ်အိဉ်စ့်ၢ်ကီးဒီး တၢ်မၤစၢၤတၢ်နၢ်ဟူဒီး တၢ်မၤစၢၤတၢ်မၤတဖဉ် လၢကဟ့ဉ်တ်ဂ့်ၢ်တၢ်ကျိၤ လၢပှၤအါဂၤနၢ်ပၢ်အီၤသ့ လၢတအိဉ်ဒီးအဘူးအလဲ ဒီးချူးဆၢချူးကတၢ်နၵ်လီၤ. ဝံသးစူၤ ကိးနိဉ်ဂံၢ်လၢထး မ့တမ့်ၢ် တဲသကိးတၢ်ဒီး ပှၤလၢအဟ့ဉ်နၤတၢ်မၤစၢၤ တက့ၢ်. ကညီကျိာ် Karen

안내: 한국어를 사용하시는 분께는 언어 지원 서비스를 무료로, 지체 없이 제공해 드립니다. 또한, 정보 접근성을 위한 적절한 보조 기구 및 서비스가 무료로, 시의적절하게 제공됩니다. 위에 있는 번호로 전화하시거나 담당자에게 말씀해 주십시오. Korean

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານຈະໄດ້ຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ແລະ ບໍ່ມີການລັກຊ້າ ທີ່ບໍ່ຈຳເປັນ. ນອກຈາກນັ້ນ, ເຄື່ອງມືຊ່ວຍເຫຼືອແລະ ບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ກະລຸນາໂທຫາເບີໂທລະສັບຂ້າງເທິງ ຫຼື ສົນທະນາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. Lao

HUBADHAA: Yoo Afaan Oromoo dubbattu ta'e, tajaajila gargaarsa turjumaana afaanii biliisaan akkasumas turtii barbaachisaa hin taane hambisu danda'u isiniif dhihaatee jira. Dabalataanis, odeeffannoo haala salphaan argamuu danda'an dhiyeessuuf gargaarsa fi tajaajiloota deeggarsaa qama midhamtootaaf mijatoo ta'an, kaffaltii tokko malee fi yeroo isaa eeggatee kennamu dhihaatee jira. Odeeffanno dabalataaf lakkoofsa armaan oliitti fayyadamuun namoota gargaarsa kana isiniif kennan qunnamaa. Oromo

ВНИМАНИЕ: Если вы разговариваете на русском языке, воспользуйтесь услугами языковой поддержки бесплатно и без лишних проволочек. Также бесплатно и незамедлительно предоставляются соответствующие вспомогательные средства и услуги по обеспечению информацией в доступных форматах. Позвоните по указанному выше номеру или обратитесь к своему поставщику услуг. Russian

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, waxaa si bilaash ah kuugu diyaar ah adeegyada caawinada luuqadeed oo aan lahayn daahitaan aan munaasib ahayn. Intaas waxaa dheer, waxaa la heli karaa adeegyada iyo kaabitaanka naafada ee haboon si macluumaadka loogu bixiyo qaabab la adeegsan karo oo bilaash ah laguna bixinayo waqqigeeda. Fadlan wac lambarka kore ama la hadal adeegbixiyahaaga. Somali

ATENCIÓN: si habla español, tiene a su disposición los servicios gratuitos de traducción sin costo alguno y sin demoras innecesarias. Además, se encuentran disponibles de forma gratuita y oportuna ayuda y servicios auxiliares adecuados con el fin de brindarle información en formatos accesibles. Llame al número indicado anteriormente o hable con su proveedor. Spanish

LƯU Ý: Nếu bạn nói tiếng Việt, bạn có thể được hỗ trợ ngôn ngữ miễn phí mà không phải chờ đợi lâu. Ngoài ra, các thiết bị hỗ trợ và dịch vụ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng có sẵn miễn phí và kịp thời. Vui lòng gọi số điện thoại phía trên hoặc trao đổi với nhân viên y tế của bạn. Vietnamese

Toll free 1-800-203-7225, TTY 1-800-688-2534

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

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

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

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း 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 ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ပက်သူဉ်ပာ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လိတဲစီနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တကွ၊်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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