BERGEN COUNTY BOARD OF SOCIAL SERVICES
216 ROUTE 17 NORTH
ROCHELLE PARK, NJ 07662-3300
www.bcbss.com

TEL. (201) 368-4200

FAX (201) 368-8710

To change your Medicaid HMO Provider please complete the attached form and return to:

By Fax

Ms. Sharronda Thompson
NJ FamilyCare
609-631-6450

By Mail

Ms. Sharronda Thompson
NJ FamilyCare
100 Hamilton Plaza, Suite 400
Paterson, NJ 07505

Or you can change your Medicaid HMO Provider by telephone:

Via Telephone

Monday to Friday • 8:00 AM to 4:30 PM •1-866-411-7782

If you have questions, please contact Ms. Sharronda Thompson at 609-631-6447.

COUNTY:

NJFAMILYCARE
Affordable health coverage. Quality care.

Expected Enrollment Date:

(For Internal Use Only)

HMO PLAN SELECTION FORM

Return by Mail

1. **Please fill in the Information Below**

NJ FamilyCare Number: _____

Head of Household: _____ Language Spoken: _____

Address: _____ City/State/ZIP: _____

Soc. Security No.: _____

Household Phone No. _____

Family Members Information:

Last Name	First	Date of Birth	Sex	Social Security Account Number

2. **Guardian Information** *(If Applicable)*
Authorized Person/Guardian (if other than applicant).

_____
Name Address Authorized Person/Guardian's Telephone Number

3. **Choose Your Health Plan**
Select the name of the HMO plan of your choice. *Please see HMO brochure for more information.*

☐ Amerigroup ☐ AmeriChoice of NJ

☐ Horizon/Mercy – BC/BS of NJ ☐ University Health Plans

4. **Sign your HMO Plan Selection Form.**
Please sign and date below. *Before signing, read Statement of Understanding. Signing below means: you have read and understand all pages of this form including the Statement of Understanding; and you give us permission to give all information obtained here and in our interview (by phone or in person) to your health plan.*

_____
Signature / Relationship to Family Members Date Witness

5. **If We Need to Reach You** ... Please give us the best phone number to reach you during the day should we need to call you about your choice.

Area Code Daytime Phone Number
(_____) _____

6. **Next Step:** If you have not talked with the HMO you have chosen once you receive your HMO ID card, call right away. See the HMO Information for toll free Member Services numbers.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Manged Care Applicant Profile

Return by Mail

Please complete as much information below as possible. This information will help your new HMO know about your health care needs

Part A

1 List Your Current Personal Doctor.

Enrollee(s)	Personal Doctor's Full Name	Address

2 List Any Specialists Who Also Treat the Enrollee(s) (for all individuals enrolling in an HMO.)

Enrollee(s)	Specialist Information	Speciality
	Name	
	Address	
	City, State, Zip	
	Telephone	
	Name	
	Address	
	City, State, Zip	
	Telephone	
	Name	
	Address	
	City, State, Zip	
	Telephone	

3 Current Medical Problems (check all that apply.)

☐ Heart	☐ Urinary Problems	☐ Paralysis	☐ Digestive/Bowel
☐ High Blod Pressure	☐ Breathing Problems	☐ Cancer	☐ Developmental Delay
☐ Contagious Disease	☐ Arthritis	☐ Seizures	☐ Hearing Loss
☐ Memory Loss	☐ Bleeding	☐ Diabetes	☐ Mental Illness

☐ Other _____

4 List Diagnosis _____

5 Treatment for Current Medical Problems / Diagnosis

_____

_____

_____

_____

6 Current Medications Used

_____

_____

_____

7a Has the enrollee(s) been hospitalized or gone to the Emergency Room within the last 12 months? ☐ Yes ☐ No

7b If yes, how many times? _____ Where? _____

7c Is the enrollee(s) going to have surgery in the next three months? ☐ Yes ☐ No

7d Is the enrollee(s) pregnant? If yes, due date: _____ ☐ Yes ☐ No

Part B Return by Mail

8. **Where Does the Enrollee(s) Live?**

NAME	At Home	Community Based Organization	Group Home, Etc.	Other
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

9. **Please Indicate the Enrollee(s) Disability.**

NAME	Vision	Hearing	Mobility	Communication	Behavior	Judgement	Memory	Other
	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	

10. **Please Indicate Any Durable Medical Equipment the Enrollee(s) Use.**

NAME	Incontinence Device	Ostomy Supplies	Diabetic Supplies	Catheter Supplies
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

NAME	Oxygen/ Suctioning	Monitors	Wheelchair	Prosthetics	Crutches/Walker/ Cane	Other
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

11. **Treatment Procedures Currently Used.**

NAME	Tube Feeding	Catheter	Oxygen/Trach	Ventilator	Preventive Care	Other
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

12. **Check All Programs the Enrollee(s) Currently Participate In or Receive.**

NAME	Home Health	Personal Care Assistance	ADDP	DDD	DYFS	Other
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

13. **Mental Health/Substance Abuse Services Used.**

NAME	Provider's Name

14. **Does the Enrollee(s) Need Special Accommodations?** (E.g. Transportation, Translator, Sign Language Interpreter, etc.)

NAME	No	Yes	If Yes, Please Specify Type and Frequency
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

STATEMENT OF UNDERSTANDING

1. I understand that becoming eligible for Medicaid will require enrollment in a managed care plan. Enrollment in a managed care plan is a separate process from becoming eligible for NJ FamilyCare, and there may be a delay of 30-45 days between the time of application for managed care and the effective date of enrollment in an HMO. I am choosing to enroll in the Health Maintenance Organization (HMO) checked on the other side of this form.

2. I understand that enrollment in an HMO means that there are some limits on where and how I can receive health care services under NJ FamilyCare.

3. I understand that unless I have a medical emergency, I must contact my personal doctor for medical care.

4. I understand that in an emergency, I must contact my personal doctor or HMO as soon as possible.

5. I understand that receiving health care services without my personal doctor or HMO approval may result in a denial of payment by the HMO., may result in my being billed for the unauthorized service, and that NJ FamilyCare will not pay for the unapproved service or visit,

6. I understand that I may call my personal doctor any time for medical advice, care or referral if I or someone in my family is sick or injured.

7. I understand that any children born to me while I am enrolled as a member of an HMO will be enrolled as a member of that HMO at birth. I also understand my responsibility to notify the NJ FamilyCare Program of any children born to me while a member.

8. I also understand that it is my responsibility to notify the HMO and NJ FamilyCare of any change in the number of my family members.

9. I understand that I must notify the Health Benefits Coordinator if I move so that I can make sure that my health plan is still in place or to choose another plan.

10. I understand that I must keep scheduled appointments or notify the doctor's office when I cannot keep an appointment.

11. I understand that I may change HMOs and that I can call a Health Benefits Coordinator for help.

12. I understand that if I change HMOs, my eligibility for NJ FamilyCare will not change.

13. I understand that I may be able to get an exemption from choosing an HMO and that I can call a Health Benefits Coordinator for help (for Plan A only).

14. I understand that I must follow NJ FamilyCare regulations to stay eligible for NJ FamilyCare.

15. I give permission for the lawful release of medical history and health care records for me and my family to any person(s) who shall provide health care to us as long as I am a member of this plan.

16. I understand that all information is confidential.

17. I give permission for the release of medical history and health care records for me and my family to any person(s) in my new HMO who shall provide or coordinate health care to me and my family to such an extent that may be lawful as long as I am a member of this plan.

18. I give permission for the release of medical history and health care records for me and my family from my prior HMO to any, person(s) in my. new HMO who shall provide or coordinate health care to me and my family to such an extent that may be lawful is long as I am a member of the new plan.

19. I give permission for the release of medical history and health care records for me and my family to the Department of Human Services for the purpose of monitoring the care provided to me and my family as long as my family and I are beneficiaries of the Medicaid/NJ FamilyCare program.

IN SIGNING THE HMO SELECTION FORM, I AM VERIFYING THAT I HAVE READ AND UNDERSTOOD THIS STATEMENT.

CONTACT A FAMILYCARE WORKER AT THE BERGEN COUNTY SOCIAL SERVICES AT 201-368-4200 TTY 201-368-4361 IF YOU HAVE ANY QUESTIONS.