



UCare Connect (Special Needs BasicCare) Enrollment Form

UCare Connect Enrollment Telephone Numbers

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

TTY for the hearing impaired at
612-676-6810 or 1-800-688-2534.

Monday – Friday, 8 am – 5 pm
The call is free.

UCare Connect Customer Services Telephone Numbers

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

TTY for the hearing impaired at
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 should 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, Hennepin, Houston, Isanti, Itasca, Jackson, 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	Gender <input type="checkbox"/> M <input type="checkbox"/> F
County you live in		Social Security number (optional)		Phone number (__) ___-____		
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		Are you pregnant <input type="checkbox"/> YES <input type="checkbox"/> NO		
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"/> (98) Other, explain _____						
Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT) or are you enrolled in the Developmental Disability waiver? <input type="checkbox"/> YES <input type="checkbox"/> NO						
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 live in a long-term facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, fill in the information below:						
Name of facility:				Phone number: (__) ___-____		
Some individuals may have other medical coverage, including other private insurance.						
Do you have other medical coverage? <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						

CHOOSE HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Remember, joining SNBC is voluntary. You can always request to drop out and change back to Medical Assistance (Medicaid) fee-for-service effective the next available month.

Primary care clinic you are choosing	Primary care clinic (PCC) number
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PLEASE READ AND SIGN PAGE 4 OF THIS FORM

Under UCare Connect, I understand that:

UCare Connect will be providing my health care covered by Medical Assistance (Medicaid).
Once I am a member of UCare Connect, I have the right to appeal any services that are being denied, reduced, or stopped, or if UCare Connect is denying payment for services.
I will be notified of the date my coverage will start.
On the date UCare Connect coverage begins, I must get my health care from UCare Connect doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get UCare Connect approval to see other providers in some circumstances.
I will read the Member Handbook I get from UCare Connect. It will have the rules I must follow and more information about the services my plan covers. Services contained in UCare Connect's Member Handbook will be covered.
Some services require authorization from UCare Connect. Without authorization, UCare Connect will not pay for these services.
My UCare Connect benefits cannot be canceled because I get sick or use health care services.
I can choose to leave UCare Connect and change back to Medical Assistance (Medicaid) fee-for-service, effective the following month. I understand that I will be enrolled in UCare Connect through the last day of the month.
My health care services will be coordinated through UCare Connect. I may have to choose a primary care clinic.
To be enrolled and stay enrolled in UCare Connect, I must: <ul style="list-style-type: none">• Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT) or be enrolled in the Developmental Disability waiver• 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 UCare Connect If this changes, I will notify my county worker and UCare Connect so I can disenroll.
If I get a medical spenddown while enrolled in SNBC and do not pay it to DHS , I will be disenrolled from UCare Connect.
If you are on Medical Assistance (Medicaid) for Employed Persons with Disabilities (MA-EPD), you must continue to pay your MA-EPD premium to remain eligible for Medical Assistance (Medicaid).

By enrolling in UCare Connect, I authorize:

The sharing of information about my Medical Assistance (Medicaid) 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:
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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።

ما أذلاحة: إرتد مسادة مجانية لتجرمة هه الوثيذقصة، ال على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរសព្ទតាមលេខខាងលើ ។

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.

ဟ်သုဉ်ဟ်သးဘဉ်တက့ၢ်. ဝဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤန့ၢ်, ကိးဘဉ်လိတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၢ်တက့ၢ်.

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

ໂປຣດຊາຍ ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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 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

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 contact any of the following four 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:

U.S. Department of Health and Human Services'
Office for Civil Rights
200 Independence Avenue SW
Room 515F
HHH Building
Washington, DC 20201
Customer Response Center: Toll-free: 800-368-1019
TDD 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 believe 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
- 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

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. After we get your complaint, 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 the outcome 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

UCare Complaint Notice

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

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

You can file a complaint and ask for help in 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