Hamaspik
MANAGED CARE

Designated Representative Authorization Form

This form allows you or your legal representative to authorize a family member or friend to receive information about your health care and to assist you in providing guidance to your home care workers. This form does not authorize the individual below to make other health care decisions about you. In order to authorize someone to make health care decisions for you, if you become unable to make decisions for yourself, you need to complete a Health Care Proxy. We have also included a copy of that form for you.

Member Name_____ Date of Birth _____

1. I authorize Hamaspik Choice to disclose my health information to the following individual for purposes of assisting with my treatment and payment for care:

   Name of Individual:_____ (the "Individual")

2. I understand that the Individual may only receive information regarding my treatment for HIV, Mental Health or Substance Abuse if I check the boxes below specifically authorizing the disclosure of such information:
   - ☐ **Alcohol/Drug Treatment**, which may include information related to your diagnoses, medications and dosages, lab tests, substance use history, discharges, employment, living situation and social supports, and health insurance claims history
   - ☐ **Mental Health Information**
   - ☐ **HIV-Related Information**

3. I further authorize the Individual to request an appeal or grievance on my behalf or to direct my CDPAS services.

4. I understand the following:
   - If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I can request a list of people who may receive or use my HIV-related information without authorization.
   - I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
   - I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
   - Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.
   - This authorization will expire on _____, or 30 days after I am no longer receiving services from Hamaspik if no date is specified.

_____ _____

Signature of Member or Legal Representative Date

_____

Relationship to Member (if signed by Legal Representative)

Please send complete form by mail to: Hamaspik Inc., 58 Route 59, Suite #1, Monsey, NY 10952. If you have questions, please call us at: 1-888-426-2774. (TTY users, call 711.)

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM AGREEMENT BETWEEN THE CONSUMER/DESIGNATED REPRESENTATIVE AND HAMASPIK MEDICARE CHOICE

Consumer Name:_____

Designated Representative Name (if applicable): _____

Health Plan Name: Hamaspik Medicare Choice

I. CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP) AGREEMENT

The Consumer Directed Personal Assistance Program (the "Program") is a program for Medicaid recipients ("Consumers") who need home care services, including help with personal care and certain home health and skilled nursing services. The Program gives Consumers more flexibility and freedom of choice by letting them direct their own care, including choosing their own personal assistants in accordance with their Health Plan's authorization.

To participate in the Program, Consumers must be able to direct their own care and understand and fulfill the Consumer's responsibilities within the Program or have a Designated Representative that will do this for them. The Consumer or Designated Representative must also understand the roles and responsibilities of the Health Plan and the Fiscal Intermediaries under the Program.

As used throughout this agreement the term "Consumer" also includes the Consumer's Designated Representative when applicable, unless otherwise specified. As used throughout this agreement the terms "I" and "my" will refer to the Consumer or alternatively to the Consumer's Designated Representative when applicable and depending on context.

This agreement outlines the roles and responsibilities of the Consumer and the Health Plan under the Program. The Consumer must enter into this agreement to acknowledge that they understand the roles and responsibilities and to participate in the Program. The Consumer must also enter into a separate agreement with their chosen Fiscal Intermediary (FI), which will outline the roles and responsibilities of the Consumer and FI.

II. RESPONSIBILITIES OF THE CONSUMER/DESIGNATED REPRESENTATIVE:

As a Consumer participating in the Program, I will:

1. Read and understand this agreement and the roles and responsibilities of the Health Plan, FI, and Consumer under the Program.

2. Only work with one FI. I understand that I can change my FI at any time, but I will work with only one at a time. If I am working with more than one FI, I must choose just one FI to continue working with.

3. Manage my plan of care.

4. Be responsible for recruiting, hiring, training, supervising, and scheduling a sufficient number of qualified individuals of my choosing to serve as my personal assistant(s) in accordance with my Health Plan's authorization.

5. Maintain a back-up plan for substitute coverage when a personal assistant is temporarily unavailable for any reason.

6. Maintain an appropriate home environment.

7. Review the plan of care with each personal assistant outlining their responsibilities.

8. Ensure my personal assistant(s) safely and competently performs only the tasks identified in the plan of care during authorized hours.

9. Comply with labor laws, providing equal employment opportunities as specifiedin the Consumer's agreement with the CDPAS FI.

10. Inform the Health Plan and FI within 5 business days of any change in statusor condition, including but not limited to hospitalizations, address and telephone number changes, and vacations.

11. Terminate a personal assistant's employment, if necessary.

12. Notify the FI of any changes in the employment status of a personal assistant.

13. Ensure my personal assistant's required documents are submitted to the CDPAP FI including annual worker health assessments and required employment documents.

14. Ensure my personal assistant(s) adhere to EVV requirements, including those outlined by the State's EVV Program Guidelines and Requirements.

15. Attest to the accuracy of the hours my personal assistant(s) worked either through the EVV data system or by signing the personal assistant's time sheet.

16. Distribute paychecks to each personal assistant, if applicable.

17. Comply with Program eligibility requirements including participating, as needed, in the required assessment and reassessment processes.

18. Report and return to the health plan any overpayment or inappropriate payments from the Medicaid program made to my personal assistant(s).

III. ADDITIONAL RESPONSIBILITIES OF THE DESIGNATED REPRESENTATIVE ONLY:

In addition to responsibilities listed above that I, as Designated Representative, must perform on behalf of the Consumer, I will:

1. Make myself available to ensure the consumer responsibilities are carried out without delay.

2. Be available and present for any scheduled assessment or visit by the independent assessor, examining medical professional or health plan when the member is not self-directing.

IV. RESPONSIBILITIES OF THE HEALTH PLAN:

The health plan must provide the Consumer with written educational materials outlining the roles and responsibilities of the Consumer to ensure they are making an educated, informed choice to receive Program services and will:

1. Determine if the Consumer (not including the Designated Representative) is eligible for the Program and whether home care or personal care services should be authorized.

2. Determine if the Consumer is able and willing to assume all responsibilities associated with participating in the CDPAP or has a Designated Representative able and willing to act on the Consumer's behalf.

3. Discuss and document that the Consumer's or Designated Representative's plan to assure adequate supports are available to meet the Consumer's needs.

4. Develop a patient centered plan of care with the Consumer or Designated Representative, outlining the tasks to be completed by the personal assistant.

5. Maintain a copy of the plan of care in the Consumer's file and give a copy tothe both the Consumer and Designated Representative.

6. Authorize the type/amount of services and number of hours required.

7. Only authorize Program services provided through one FI and work with the Consumer or Designated Representative to select just one FI should the health plan become aware that services are being provided by more than one FI.

8. Evaluate on an ongoing basis whether the Consumer requires personal care, home health care, or some other level of service.

9. Notify the Consumer and Designated Representative that Program services are being decreased or discontinued if the health plan determines such services are no longer appropriate and, if applicable, refer the Consumer to other appropriate programs.

10. Provide the Consumer and Designated Representative with the appropriate fair hearing notice.

ALL PARTIES ACCEPT THE ROLES AND RESPONSIBILITIES TO PARTICIPATE IN THE CDPAP AS EXPLAINED ABOVE. FULFILLING THE CONSUMER'S ROLES AND RESPONSIBILITIES IS A REQUIREMENT OF PARTICIPATION IN THE PROGRAM. FAILURE TO FULFILL THE CONSUMER'S ROLES AND RESPONSIBILITIES MAY RESULT IN DISCONTINUANCE OF PROGRAM SERVICES.

Signatures

_____ _____
Consumer Date

_____ _____
Designated Representative (If applicable) Date

_____ _____
Health Plan Representative Date