FIS 18-218
Additional Information

100116839

BFA Form 330
01/19

Department of Health and Human Services
Granite Advantage Health Care Program
P.O. Box XXXX, Attn: Granite Advantage Health Care Program Manager
Concord, NH 03301
Fax 603-271-5623

Exemption Request Form
Granite Advantage Health Care Program

Use this form to request an exemption from the Granite Advantage Community Engagement requirements. **DETAILED INSTRUCTIONS ARE ON THE BACK OF THIS FORM.** If a licensed medical professional must certify the exemption, ask them to complete the Section III at the bottom of the form.

Name: _____ _____
Last First

Medicaid ID#: _____

Section I. Self-attested exemptions and exemptions requiring MEMBER ACTION		
O	Participation in State Certified Drug Court Program	Attach a copy of the Court Order
O	Parent/Caretaker of Dependent Child Under 6	No Verification Required
O	Pregnant or Within 60 Days Post-partum	Due Date:

By filling in the circle for an exemption and signing this form, I attest under penalty of unsworn falsification pursuant to RSA 641:3 that the information provided to the department in support of this request is true to the best of my knowledge and belief.

_____ _____
Member Signature Date

Section II. Exemptions requiring CERTIFICATION BY A LICENSED MEDICAL PROFESSIONAL		
O	ADA Disability	Licensed Medical Professional
O	Caretaker Residing With Immediate Family Member with ADA Disability	Licensed Medical Professional
O	Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient Treatment	Licensed Medical Professional
O	Hospitalization or Serious Illness	Licensed Medical Professional
O	Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness	Licensed Medical Professional
O	Parent/Caretaker of Developmentally Disabled Child	Licensed Medical Professional
O	Parent/Caretaker of Family Member Requiring Care	Licensed Medical Professional

For any Parent or Caretaker exemption above, enter the information for the person being cared for below:

Full Name: _____ _____
Last First

Date of Birth: MM DD YYYY

RID#: 012345678
ID : AE0149

BFA SR 19-03
(A)

Section III. Licensed Medical Professional Section

As a licensed medical professional caring for this Member, I hereby certify (based on the description of the exemptions provided in the instructions to this form) that the Member meets the qualifications for the exemption(s) requested in Section II above.

This certification is valid through (may not exceed one year): M M | Y Y Y Y

Provider Name (Please Print):	NPI #
Date	Contact #: ( )

Provider Signature: _____

Instructions For Completing the Form

Member Instructions:

1. Complete your member information and sign the top section of the form.
2. After reviewing the description of the various exemptions below, fill in the circle in the far-left column of the row which applies to the exemption(s) that you are requesting.
3. If you are requesting an exemption as a parent or a caretaker, enter the name and DOB of the person being cared for.
4. If the exemption type requires certification by a licensed medical professional, request that the licensed medical professional complete the bottom section of the form.
5. The member MUST return this form to the Department of Health and Human Services either by mail at the address above, by fax to 603-271-5623 or by uploading the form to NH EASY. The form can be uploaded to NH Easy by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the form. A Member may upload the form to NH EASY for an exemption that requires certification by a licensed medical professional ***only*** if the licensed medical professional has certified that the member meets the qualifications for an exemption.

Licensed Medical Professional Instructions:

1. Review the Description of Exemptions below and the exemption(s) that the member has selected in Section II of the form for accuracy.
2. Enter the certification end-date for the exemption if known.
3. Fill in your provider information and sign the bottom section of the form.
4. If you are submitting this form on behalf of the member, please send it to the return address on the front page, or fax it to 603-271-5623.

Description of Exemptions

Participation in State Certified Drug Court Program	The Member is participating in a state certified drug court program that has been certified by the administrative office of the superior court.
Parent/Caretaker of Dependent Child Under 6	The member is a custodial parent or caretaker of a dependent child under 6 years of age.
Pregnant or Within 60 Days Post-partum	The Member is pregnant or within 60 days post-partum.
ADA Disability	The member has a disability as defined by the Americans with Disabilities Act (ADA) and is unable to comply with the community engagement requirement due to disability-related reasons.
Caretaker Residing With Immediate Family Member with ADA Disability	The member resides with an immediate family member who has a disability as defined by the Americans with Disabilities Act (ADA) and is unable to meet the community engagement requirement for reasons related to the disability of that family member. This exemption requires that a licensed medical professional certify the family member's disability.
Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient Treatment	The member is unable to participate in the requirements due to serious illness, hospitalization, incapacity, or treatment, including inpatient or residential outpatient treatment. This exemption includes the member's participation in inpatient and residential outpatient substance use disorder treatment or in intensive outpatient substance use disorder services that is consistent with ASAM Levels 2.1 and above.

RID# 012345678
ID : AE0149

Hospitalization or Serious Illness	The member experiences a hospitalization or serious illness.
Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness	The member resides with an immediate family member who experiences a hospitalization or serious illness.
Parent/Caretaker of Developmentally Disabled Child	The member is a custodial parent or caretaker of a child with developmental disabilities who is residing with the parent or caretaker. This exemption requires that a licensed medical professional certify the child's developmental disability.
Parent/Caretaker of Family Member Requiring Care	The member is a custodial parent or caretaker who is required to be in the home to care for another relative who resides in the same household due to that individual's illness, incapacity or disability and there is no other household member to provide the care.

Department of Health and Human Services
Granite Advantage Health Care Program
P.O. Box XXXX, Attn: Granite Advantage Health Care Program Manager
Concord, NH 03301

BFA Form 320A
01/19
Fax #: 603-271-5623

Member Authorization for Licensed Medical Professional to Release Protected Health Information – Granite Advantage Health Care Program

This form authorizes a licensed medical professional to release to the Department of Health and Human Services (Department) a member's protected health information (PHI) related to the licensed medical professional's certification of the member as medically frail. This form should be completed by the member and given to the licensed medical professional who is completing the Licensed Medical Professional Certification of Medical Frailty Form.

The Member **MUST** return copy of this form along with a copy of the Licensed Medical Professional Certification of Medical Frailty Form to the Department. The forms may be sent to the Department by mail (at the address above), by fax to 603-271-5623 or by uploading the forms to NH EASY. The forms can be uploaded to NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the forms. A Member may upload the forms to NH EASY ***only*** if the licensed medical professional has certified that the member is medically frail.

Part I. Member Information (please print)

Last Name:	First Name, Middle Initial:	Date of Birth MM/DD/YYYY
Residential Street Address (if homeless write N/A):	City, State, Zip Code:	Phone #: ( )

Part II. Purpose of the Disclosure The purpose of the disclosure of PHI pursuant to this release is to verify the licensed medical professional certification that the member is medically frail and that the member is accordingly exempt from the Granite Advantage Health Care Program community engagement requirements. I understand that if I do not authorize the release of this information, I will not be able to demonstrate that I qualify for an exemption with the necessary completion of the Licensed Medical Professional Certification of Medical Frailty Form.

Please check all that apply below:

☐ I hereby authorize the following licensed medical professional to disclose my protected health information for the purposes described above:

Name of Medical Professional: _____
Organization: _____Telephone #: (_____) _____--_____
Address: _____

☐ In addition, I hereby authorize the following specific disclosures (Place your initials on the line by those statements which apply)

_____ I specifically authorize the release of my mental health treatment records.
_____I specifically authorize the release of my HIV and AIDS results and/or treatment.
_____ I specifically authorize the release of my alcohol and/or drug abuse treatment records in accordance with 42 CFR Part 2.
_____ Other (specify): _____.

☐ I give authorization for my protected health information to be released to the following individual **or** organization:

Name: Granite Advantage Health Care Program Manager
Organization: Department of Health and Human Services
Address: DHHS, Granite Advantage Health Care Program, P.O. Box XXX, Concord, NH 03301 or Fax# 603-271-5623

☐ I understand this authorization may be revoked by notifying the Department of Health and Human Services in writing to the address above.

☐ This authorization will expire one year from the date it is signed.

_____ _____

Signature of Member or Duly Authorized Legal Representative Date

If you have any questions regarding this form, please call the Department's Medicaid customer services number at 1-844-275-3447 (1-844-ASK-DHHS).

Department of Health and Human Services
Granite Advantage Health Care Program
P.O. Box XXXX, Attn: Granite Advantage Health Care Program Manager
Concord, NH 03301

100116889

BFA Form 331
01/19

Licensed Medical Professional Certification of Medical Frailty

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Granite Advantage Health Care Program

This certification is to be completed by a licensed medical professional who is qualified to assess the Member for "medical frailty". This certification will be used to support the determination that the member is medically frail and exempt from the community engagement requirement for the Granite Advantage Health Care Program (Granite Advantage).

The Member **MUST** return this form along with a copy of the Member Authorization for Licensed Medical Professional to Release Protected Health Information Form to the Department. The forms may be sent to the Department by mail (at the address above), by fax to 603-271-5623 or by uploading the forms to NH EASY. The forms can be uploaded to NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the forms. A Member may upload the forms to NH EASY ***only*** if the licensed medical professional has certified that the member is medically frail.

"Medically frail", as defined in 42 CFR 440.315 (f), includes: individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, as well as individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living.

Part I. Member Information (please print)

Last Name:	First Name, Middle Initial:	Medicaid ID #: | | | | | | | | | |
Residential Street Address (if homeless write N/A)	City, State, Zip Code:	Phone #: ( )
Date of Birth MM/DD/YYYY	Gender M F	

Part II. Licensed Medical Professional Certification

As a licensed medical professional caring for this Member, I hereby certify that the member is medically frail based on the member having one or more of the conditions identified in Part III below:

Part III. Medically Frail Condition

Please check ALL the appropriate boxes in the table that best defines the medically frail condition of the Member:	
Definition	Category
Individuals with disabling mental	☐ Psychotic disorder ☐ Schizophrenia

health disorders	☐ Schizoaffective disorder ☐ Major depression ☐ Bipolar disorder ☐ Delusional disorder ☐ Obsessive-compulsive disorder ☐ Other mental health condition: specify_____
Individuals with substance use disorders	☐ The Member has a diagnosis of substance use disorder consistent with DSM-V* criteria. *DSM-V means the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
Individuals with serious and complex medical conditions	☐ The individual meets criteria for hospice services, **OR** ☐ The individual has a serious and complex medical condition **AND** the condition significantly impairs the ability to perform one or more activities of daily living (ADLs).
Individuals with a physical disability	☐ The individual has a physical disability **AND** the condition significantly impairs the ability to perform one or more activities of daily living (ADLs).
Individuals with an intellectual or developmental disability	☐ The individual has an intellectual disability or a developmental disability as described below **AND** the condition significantly impairs the ability to perform one or more activities of daily living (ADLs) ○ Intellectual Disability means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior ○ Developmental Disability means a disability attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or a specific learning disability, or any other condition of an individual found to be closely related to an intellectual disability as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that for persons with an intellectual disability, that ○ Is manifested before the age of 22; ○ Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of a lifelong or extended duration and are individually planned and coordinated.

Provider note including any other considerations that should be given to support "Medical Frailty" of this individual:

_____

This certification is valid through MM/DD/YYYY (May not exceed one year).

Provider Name (Please print):	NPI # | | | | | | | | | |
Date	Contact #: ( )

Provider Signature:

_____

NH Department of Health and Human Services
Granite Advantage Health Care Program
P.O. Box XXX, Attn: Granite Advantage Health Care Program Manager
Concord, NH 03301
Fax (603) 271-5623

BFA Form 340
01/19

Good Cause Request Form

Granite Advantage Health Care Program

Use this form to request good cause to excuse the inability to meet the community engagement hours for the previous month. **DETAILED INSTRUCTIONS ARE ON THE BACK OF THIS FORM**. Print all information in the spaces provided and include 3rd party verification where required.

Name: _____ _____
Last First

Medicaid ID#: _____

By filling in the circle for good cause and signing this form, I attest under penalty of unsworn falsification pursuant to RSA 641:3 that the information provided to the department in support of this request is true to the best of my knowledge and belief.

_____ _____
Member Signature Date

FOR THE MONTH OF (MM/YYYY): _____

	Good Cause Reason	Self-Attestation and Verification	Crediting a finding of Good Cause
O	Birth or death of family member	Name of family member:_____ Date of event:_____ Relationship: _____	# of days at 8 hrs/day _____
O	Severe inclement weather	Date(s) of event: _____	# of days at 8 hrs/day _____
O	Family emergency or life changing event	Description of event: _____ Date(s):_____	# of days at 8 hrs/day _____
O	Parent/caretaker of child 6-12 unable to secure child care	Self-attestation of inability to secure child care	# of days at 8 hrs/day _____
O	Homeless or unable to find stable housing	Self-attestation	# of days at 8 hrs/day _____

	Good Cause Reason	Attestation and Verification	Crediting a Finding of Good Cause
O	Domestic violence	Court Order **OR** Self-Attestation	Date range specified in Court Order at 8 hrs/day **OR** # of days at 8 hrs/day ________
O	ADA disability	Self-attestation **AND** Certification by licensed medical professional	Date range specified by licensed medical professional at 8 hrs/day **OR** If no date range indicated, 100 hours.________
O	Caretaker Residing with Immediate Family Member with ADA Disability.	Self-Attestation **AND** Certification by licensed medical professional of family member's disability and duration.	Date range specified by licensed medical professional at 8 hrs per/ day **OR** If no date range indicated 100 hours ________
O	Inpatient Hospitalization	Self-Attestation **AND** Medical documentation to substantiate	100 hrs/month.
O	Outpatient Hospitalization or Serious Illness	Self-Attestation **AND** Medical documentation to substantiate	Date range specified by licensed medical professional at 8 hrs per/ day **OR** If no date range indicated # days at 8 hrs/day ________
O	Caretaker Residing with Immediate Family Member Who Experiences Inpatient Hospitalization	Self-Attestation **AND** Medical documentation to substantiate family member's hospitalization	# of days at 8 hrs/day ________
O	Caretaker Residing with Immediate Family Member Who Experiences Outpatient Hospitalization or Serious Illness	Self-Attestation **AND** Medical documentation to substantiate family member's hospitalization or serious illness	Date range specified by licensed medical professional at 8 hrs per/ day **OR** If no date range indicated # days at 8 hrs/day ________
O	Good Cause Related to a Temporary Increase in Monthly Employment Hours	Self-Attestation	# of extra employment hours ________
O	Other Good Cause	Self-Attestation	# of other good cause days at 8 hrs/day _______

For any Parent or Caretaker good cause above, enter the information for the person being cared for below:

Full Name: ____________________ ____________________

Last First

Date of Birth: MM DD YYYY

Licensed Medical Professional Certification

A showing of good cause for "ADA disability" or "Caretaker Residing with Immediate Family Member with ADA Disability" requires certification by a licensed medical professional. As a licensed medical professional caring for this Member or for a Member's family member with a disability, I hereby certify that:

O The *member* is disabled and unable to meet the community engagement requirement for reasons related to their disability; or

O The *family member identified above* is disabled

The duration of the disability of the member or family member if known is: M M D D Y Y

Provider Name (Please Print):	NPI #
Date	Contact #: ( )

Provider Signature: _____

Instructions for Completing the Form

Member Instructions

1. Complete your member information and sign the top section of the form.
2. After reviewing the descriptions of good cause below, fill in the circle in the far-left column of the row which applies to the good cause that you are requesting.
3. If you are requesting good cause as a parent or a caretaker, enter the name and date of birth off the person being cared for.
4. If the good cause type requires certification by a licensed medical professional, ask the licensed medical professional to complete the Licensed Medical Professional Certification section of the form.
5. If the good cause type requires medical documentation, attach the necessary documentation to this form.
6. The member MUST return this form to the Department of Health and Human Services either by mail at the address above, by fax to (603) 271-5623 or by uploading the form to NH EASY. The form can be uploaded to NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the form. A member may upload the form to NH EASY for good cause that requires certification by a licensed medical professional ***only*** if the licensed medical professional has certified that the member meets the required qualifications.

Licensed Medical Professional Instructions:

1. Review the Descriptions of Good Cause below for "ADA disability" or "Caretaker Residing with Immediate Family Member with ADA Disability" that the member has selected.

2. If, the member is disabled and unable to meet the community engagement requirement for reasons related to their disability or if the member's immediate family member identified above is disabled, select the appropriate certification box.
3. Enter the good cause end-date if known.
4. Fill in your provider information and sign the bottom section of the form.
5. If you are submitting this form on behalf of the member, please send it to the return address on the front page or fax it to (603) 271-5623.
6. If you determine that the member or the member's immediate family member is ***not*** disabled, please return this form directly to the department at the address on the front page or fax it to (603) 271-5623.

Descriptions of Good Cause

Birth or Death of a Family Member	For a beneficiary who experiences the birth or death of a family member residing with the beneficiary, a showing of good cause requires self-attestation of the event to include the name of the family member, the date of the event and the family member's relationship to the beneficiary as well as the number of community engagement hours that the beneficiary was unable to complete due to the circumstance at 8 hours per day.
Severe Inclement Weather	For a beneficiary who experiences severe inclement weather including a natural disaster, a showing of good cause requires the date(s) of the event and self-attestation of the number of days the beneficiary was unable to participate due to the circumstance at 8 hours per day.
Family Emergency or Life Changing Event	For a beneficiary who has a family emergency or other life changing event such as divorce, a showing of good cause requires attestation of the nature of the family emergency or life changing event to include the number of days that the beneficiary was unable to participate due to the circumstance at 8 hours per day.
Parent/caretaker of Child 6-12 Unable to Secure Child Care	For a beneficiary who is a custodial parent or caretaker of a child 6 to 12 years of age and who is unable to secure child care in order to participate in qualifying community engagement either due to a lock of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor, a showing of good cause requires monthly self-attestation of the inability to secure child care and the number of hours the beneficiary was unable to complete toe to the circumstance at 8 hours per day.
Homeless or Unable to Find Stable Housing	For a beneficiary who is homeless or unable to find stable housing, a showing of good cause requires self-attestation of the number of days the beneficiary was unable to complete due to the circumstance at 8 hours per day.

Domestic Violence	For a beneficiary who is a victim of domestic violence, dating violence, sexual assault or stalking, a showing of good cause requires a copy of the court order which indicates that the beneficiary was the victim of domestic violence, dating violence, sexual assault or stalking **OR** the beneficiary's self-attestation of domestic violence, dating violence, sexual assault or stalking. Hours will be credited based on the date range specified in the court order at 8 hours per day or based on the beneficiary's self-attestation of the number of days the beneficiary was unable to complete due to the circumstance at 8 hours per
ADA Disability	For a beneficiary who has a disability and was unable to meet the requirement for reasons related to that disability but was not exempted from community engagement requirements, a showing of good cause requires attestation that the beneficiary was unable to meet the community engagement requirement for reasons related to the disability **AND** certification by a licensed physician of the beneficiary's inability to meet the community engagement requirement for reasons related to the disability. Hours will be credited based on the date range specified by the beneficiary's medical provider at 8 hours per day or if no date range is indicated, 100 hours for one month.
Caretaker Residing with Immediate Family Member with ADA Disability	For a beneficiary who resides with an immediate family member who has a disability, and was unable to meet the requirement for reasons related to the disability of that family member, but was not exempted from community engagement requirements, a showing of good cause requires attestation of the number of days the beneficiary was unable to meet the community engagement requirement for reasons related to that disability **AND** certification by the family member's physician specifying the family members disability and the duration, if know. Hours will be credited based on the date range specified by the family member's medical provider at 8 hours per day or if no date range is indicated, 100 hours for one month.
Inpatient Hospitalization	For a beneficiary who experienced inpatient hospitalization but was not exempted from community engagement requirements a showing of good cause requires attestation of the number of days of the hospitalization **AND** copies of the beneficiary's physician, hospital or other medical records that would substantiate the hospitalization. Hours for inpatient hospitalization will be credited at 100 hours for one month.
Outpatient Hospitalization or Serious Illness	For a beneficiary who experienced outpatient hospitalization or serious illness but was not exempted from community engagement requirements a showing of good cause requires attestation of the number of days of hospitalization or serious illness **AND** copies of the beneficiary' physician, hospital or other medical records that would substantiate the hospitalization or serious illness. Hours for outpatient hospitalization or serious illness will be credited based on the date range specified by the beneficiaries medical provider at 8 hours per day or if no date range is indicted based on the beneficiaries self-attestation of the number of hours at 8 hours per day.

Caretaker Residing with Immediate Family Member who Experiences Inpatient Hospitalization or Serious Illness	For a beneficiary who resides with an immediate family member who experienced inpatient hospitalization or serious illness, but the beneficiary was not exempted from community engagement requirements, a showing of good cause requires self-attestation of the number of days the beneficiary was unable to complete due to the circumstance at 8 hours per day **AND** copies of the family member's physician, hospital or other medical records that would substantiate the inpatient hospitalization or serious illness. Hours will be credited based on the date range specified by the family member's medical provider at 8 hours per day or if no date range is indicated, based on the beneficiaries self-attestation of the number of hours at 8 hours per day.
Caretaker Residing with Immediate Family Member who Experiences Outpatient Hospitalization or Serious Illness	For a beneficiary who resides with an immediate family member who experienced outpatient hospitalization or serious illness, but the beneficiary was not exempted from community engagement requirements, a showing of good cause requires self-attestation of the number of days the beneficiary was unable to complete due to the circumstance at 8 hours per day **AND** copies of the family member's physician, hospital or other medical records that would substantiate the outpatient hospitalization or serious illness. Hours will be credited based on the date range specified by the family member's medical provider at 8 hours per day or if no date range is indicated, based on the beneficiaries self-attestation of the number of hours at 8 hours per day.
Good Cause Related to a Temporary Increase in Monthly Employment Hours	A temporary increase in monthly employment hours for seasonal or other work that is above the beneficiary's average monthly employment hours as determined in He-W 837.15(a)(11)(b) may be reported as good cause. The reporting of additional employment hours as good cause under this section shall be limited to 2 consecutive months.
Other Good Cause	Other good cause requires self-attestation of the circumstances beyond the beneficiary's control which relate to the beneficiary's ability to obtain or retain a qualifying activity to participate in and the number of hours the beneficiary was unable to complete at 8 hours per day.