Enrollment Agreement

Name:_____ Date of Birth: _____

Gender: _____ Telephone: _____

Address: _____

Health Care Proxy □ Check if you do not have a Health Care Proxy

Name:_____ Relationship to Participant: _____

Address: _____

Telephone: _____

Guardian or Other Legal Representative

Name:_____ Legal Relationship to Participant: _____

Address: _____

Telephone: _____

Important Notice: *The benefits under this contract are made possible through a special agreement among the East Boston Neighborhood Health Center (Neighborhood PACE), the US Department of Health and Human Services, Centers for Medicare & Medicaid Services and the Commonwealth of Massachusetts Office of MassHealth. The agreement is subject to renewal on a periodic basis and, if the agreement is not renewed, the program will be terminated.*

When you sign the Neighborhood PACE Enrollment Agreement, you are agreeing to accept services exclusively from Neighborhood PACE in place of the usual Medicare and MassHealth benefits as outlined in the Enrollment Agreement. Please examine the Enrollment Agreement carefully. You are under no obligation to enroll in our plan. You may cancel your enrollment if you notify Neighborhood PACE before the effective date noted below.

The following information was reviewed with me before I signed this enrollment agreement: ☑ Initial _____(Participant or Witness)

- ☐ My Initial Care (Service) Plan
- ☐ Benefits & Coverage
- ☐ Service Request/Appeals Process
- ☐ Access to After Hours, Emergency & Urgent Care
- ☐ Eligibility, Enrollment &Disenrollment
- ☐ Grievance & Appeals Process
- ☐ Monthly Payment Obligations (if applicable)
- ☐ Participant Rights

I authorize the exchange of information between the Centers for Medicare & Medicaid Services (CMS), the state-administering agency (MassHealth), and the East Boston Neighborhood Health Center (Neighborhood PACE). Initial _____(Participant or Witness)

I agree to provide timely financial and other documentation as required by MassHealth and/or Medicare to maintain insurance coverage through Neighborhood PACE. Initial _____(Participant or Witness)

I understand that all services, with the exception of emergency services, require prior authorization. Without prior authorization from Neighborhood PACE, I may be responsible for costs for services. Initial _____(Participant or Witness)

Current Coverage and Fees

Fees and co-pays vary based on your entitlements to public insurance coverage.

The fees you pay for coverage under Neighborhood PACE depend on your eligibility for MassHealth and Medicare. Your current coverage is indicated by ☑ below.
Initial _____(Participant or Witness)

☐ Medicare A/B/D **AND** MassHealth ("Dually Eligible") - No fees or co-pays

☐ Medicare A/B/D AND MassHealth with **Spend down*** ("Dually Eligible") – see spend monthly obligation below.

☐ MassHealth only – No fees or co-pays

☐ MassHealth only with **Spend down*** --see spend monthly obligation below.

Spend downs are determined by Masshealth and are based on income.

☐ Medicare A and/or B only—you will pay the current private pay rates that include: Medicare A and/or B premiums, a premium for Medicare Part D as well as the applicable MassHealth premium. See applicable fees below.

I understand that my cost to remain enrolled with Neighborhood PACE will be $_____ per month. Payment is due on the first of each month beginning the first day of Enrollment and are non refundable. The monthly fee is subject to change due to changes in your income and Medicare and MassHealth regulations. (You will receive notification of such changes.) Failure to meet payment obligations may result in involuntary disenrollment. Please call the Business Office at 617-568-7214 with any questions or to set up a payment arrangement.

If you were not eligible for Medicare when you enrolled in Neighborhood PACE but become eligible while you are enrolled, Neighborhood PACE will notify you of your new entitlement approximately 30 days from the date that your Medicare eligibility becomes active. I understand that if I choose to remain enrolled in Neighborhood PACE after I become eligible for Medicare, I will receive all of my Medicare Covered Services, including Part D prescription coverage, through Neighborhood PACE.

I understand that electing enrollment in any other Medicare Part D or Medicaid prepayment plan or optional benefit, including the hospice benefit, after enrolling as a PACE participant, is considered voluntary disenrollment from PACE.

I have received, read, and understand the Enrollment Agreement terms and the conditions in the contract have been explained to me. I have been given the opportunity to ask questions. All of my questions have been answered to my satisfaction. I agree to participate in East Boston Neighborhood Health Center's Neighborhood PACE according to the terms and conditions described in this Enrollment Agreement, and I specifically agree to receive all health services and health-related services from Neighborhood PACE and its network of providers, with the exception of *emergency* services, or with prior authorization in the event that I require out of network services.

I understand that my enrollment with Neighborhood PACE will be effective on _____.

_____

Print name of participant or designated representative

□ *Check here if designated representative is the participant's legal guardian*

_____ _____

Signature of participant or designated representative Date

_____

Print name of witness

_____ _____

Signature of witness Date

A copy of the Enrollment Agreement is provided to the participant and scanned into the Participant's Medical Record.

Neighborhood PACE complies with applicable Federal and Commonwealth of Massachusetts' civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

If you have additional questions, call 1-617 568-6377 (TTY: 800-439-0183). If you speak a language other than English, language assistance services, free of charge, are available to you.

Si usted tiene preguntas adicionales, Llame al 1-617-568-6377 (TTY: 800-439-0183). Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística

Se você precisa de mais informações, Ligue para 1-617-568-6377 (TTY: 800-439-0183). Se fala português, encontram-se disponíveis serviços linguísticos, grátis.