ELDERWOOD HEALTH PLAN ENROLLMENT AGREEMENT

Name_____ **Date of Birth**_____

Address_____ **Medicaid #**_____

NY Zip Code_____ **County**_____

☐Yes ☐ No I wish to enroll in the Elderwood Health Plan and understand that enrollment is voluntary.

☐Yes ☐ No I have received and have had the Member Handbook explained to me, which includes the rules and responsibilities of plan membership and a description of covered and non-covered services.

☐Yes ☐ No I agree to participate in the Elderwood Health Plan according to the terms and conditions described in the Member Handbook.

☐Yes ☐ No I understand that I may choose to disenroll from Elderwood Health Plan by giving written or oral notice and Elderwood Health Plan will notify me of the effective date of disenrollment.

☐Yes ☐ No As an enrollee, I agree to receive all covered services from Elderwood Health Plan Provider Network. I have received a copy of the Provider Network Directory.

☐Yes ☐ No I understand that I am free to choose my primary care physician and any specialist physicians, as these services are **NOT** covered services of the Elderwood Health Plan.

☐Yes ☐ No I understand that my date of enrollment is expected to be _____.

☐Yes ☐ No I understand that if I have a Medicaid Spend-down/Surplus as a condition of my Medicaid eligibility, I agree to pay Spenddown/Surplus to Elderwood Health Plan.

☐Yes ☐ No I understand that my Enrollment Application must be confirmed by New York Medicaid Choice/Local Department of Social Services (LDSS).

☐Yes ☐ No I give permission to Elderwood Health Plan to obtain my digital image (photo) to use on my ID card and in my medical record only. Elderwood Health Plan agrees NOT to use my photo in any promotional or marketing materials.

☐Yes ☐ No If I am or become a resident in a nursing facility, I agree to a referral to New York State's contractor for Money Follows the Person/Open Doors, a program that can work with my MLTC plan to help me return to community living.

Enrollee Name (print)	**Signature of Enrollee**	**Date**
Name of Legal Representative (if applicable)	**Signature of Legal Representative**	**Date**
Witness Name	**Signature of Witness**	**Date**

For enrollees who do not speak English as a first language: I, _____ (Translator),

have read and translated this enrollment agreement in the primary language _____(Enrollee), speaks.

Signed _____ Date _____