NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Consent Form for NC Medicaid Coverage of Healthy Opportunities Pilot Services

If the Member's Care Manager or Health Plan has indicated that the Member may meet the eligibility criteria for Healthy Opportunities Pilot services, the Member may be eligible for Medicaid coverage of food, housing, transportation, interpersonal safety, toxic stress, or cross-domain services at no cost to the Member.

PLEASE COMPLETE THIS FORM WITH THE MEMBER'S CARE MANAGER. THE CARE MANAGER MAY COMPLETE THE FORM FOR THE MEMBER. (* = required)

For the Care Manager: Please complete this form with the Member, attach it to the Eligibility and Enrollment Request in NCCARE360, and send the Eligibility and Enrollment Request via NCCARE360 to the Member's health plan prior to referring the Member to Pilot services, including passthrough services.

If you are completing this form for the Member over the phone or virtually, please verify the Member's identity before obtaining the Member's consent. This includes either:

1. Having the Member confirm their full name, date of birth, and at least one other piece of identifying information, or
2. Obtaining evidence that an authorized representative has a valid signed authorization to act on the Member's behalf regarding health decisions.

Please read the following script to the Member and check the appropriate box:

"I am going to read you a consent form to obtain your verbal consent to participate in the Healthy Opportunities Pilot. If you have any questions about the form, you may interrupt me at any time. I will record your responses to the questions on the form. Do you consent to my reading and recording the information you provide and your consent on this form?"

☐ Yes ☐ No

I. Member Information.

First Name* | Last Name*

AmeriHealth Caritas North C | | Avery

Health Plan Name* | Medicaid ID* | County of Residence*

Is it OK for Pilot partners to contact you at the preferred contact information, dates, and times you included in NCCARE360?*

☐ Yes ☐ No ☐ Prefer not to answer

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II. Service Coverage. Healthy Opportunities Pilot services address food, housing, transportation, interpersonal safety, and toxic stress needs. These services are available through a special NC Medicaid program for individuals that meet certain eligibility criteria and are not traditional Medicaid benefits. Eligibility for and use of these services have no impact on a Member's ongoing Medicaid eligibility and coverage.

The Member understands the following statements about receiving Pilot services:*
(These statements are informational only. The Member may answer "No" and still be eligible for Pilot services.)

1. The Member can choose not to have Medicaid pay for Pilot services at any time and revoke this consent at any time.	☐ Yes ☐ No
2. If the Member chooses not to have Medicaid pay for Pilot services or revokes this consent, the Member has the option to have Medicaid pay for Pilot services again at any time if the Member is still eligible.	☐ Yes ☐ No
3. If the Member becomes ineligible for Pilot services or if funding for Pilot services runs out, Medicaid may no longer pay for Pilot services for the Member and the Member's Care Manager will refer the Member to other services that meet the Member's needs. The Member may need to pay for other, non-Pilot, services out of pocket.	☐ Yes ☐ No
4. The Member's Care Manager must reassess whether the Pilot services the Member is currently receiving are meeting the Member's needs at least once every three months and must ensure the Member is still eligible for services at least once every six months. If the Member does not participate in an eligibility assessment every six months, Medicaid will no longer pay for the Member's Pilot services. If the Member participates in the necessary reassessments, Medicaid will pay for Pilot services for the Member until the Member is no longer eligible for Pilot services, does not need Pilot services, or Pilot funding is no longer available.	☐ Yes ☐ No
5. If the Member is found ineligible for Pilot services, the Member can request to have their eligibility status reassessed if their health status or life circumstances change.	☐ Yes ☐ No
6. If the Member is determined eligible, Pilot services will be available at no cost to them.	☐ Yes ☐ No
7. The Member has the right to refuse to consent to participate in the Pilot program. If the Member chooses not to give consent to participate in the Pilot program, the Member's care manager will work with the Member to find other services that meet their needs. The Member may need to pay for other, non-Pilot, services out of pocket.	☐ Yes ☐ No

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To have Medicaid pay for Pilot services, you must agree to the following statement:*

If determined eligible, I consent to the Member's participation in the Healthy Opportunities Pilot and having NC Medicaid pay for Pilot services.

☐ Agree ☐ Do not agree

III. Information Sharing. The purpose of this consent is to allow organizations that will help the Member get Pilot services send and receive necessary information. If the Member is determined eligible, the Member will get Pilot services through a referral process. The Member's Care Manager will recommend services, their health plan will authorize services, and a community organization will deliver the services. When the Member works with this community organization, the Member can expect that the organization also will request permission before sharing any of the Member's information with other organizations. This is especially true if the Member is receiving services to address interpersonal safety.

The community organization will submit invoices to the Member's health plan to get paid for delivering the services. The referral and invoice processes will require these organizations to share certain personal health information. Some data will also be used to evaluate the program and Pilot services.

Information about the Member that may be shared includes: the Member's name, Medicaid ID number, date of birth, address, contact information, Pilot service eligibility criteria, Pilot service authorization number, Pilot services the Member is recommended and/or authorized to receive, and supporting documentation for the purposes of determining eligibility for pilot services, obtaining coverage of Pilot services, coordinating care, payment of services, healthcare operations, and program evaluation.

Access to personal information will be limited based on the needs of the Pilot-participating organization. Only the minimum information required by the organization to fulfill their program responsibilities will be shared. When necessary, information may be shared with:

- The Member's care management team to recommend Pilot services and provide care management
- The Member's health plan to authorize and pay for Pilot services for the Member
- An organization in the community who has received a referral for the Member or who delivers pilot services to the Member
- The Healthy Opportunities Network Lead in the Member's area
- The North Carolina Department of Health and Human Services
- The University of North Carolina Sheps Center for Health Services Research for use in the evaluation of the Pilot as required in the State's 1115 Medicaid waiver
- The Centers for Medicare and Medicaid Services or State Auditor in the case of an audit

Health information shared, consistent with this consent, may no longer be protected by privacy and confidentiality laws and may be subject to redisclosure by the recipient.

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To have coverage of Pilot services, you must agree to the following statement:*

I agree to have the Member's personal health information shared with the entities described above, in the manner described above, for the purposes of obtaining coverage of Pilot services, coordinating care, payment of services, operations, and program evaluation.

☐ Agree ☐ Do not agree

IV. Signature. *By signing this form, you voluntarily consent to the Member's participation in the Healthy Opportunities Pilot Program, if determined eligible, and authorize the use and disclosure of the Member's health information as specified in this form. You also confirm that you have read this consent, or that it has been read to you, and understand that a copy of this signed consent will also be put in the Member's medical record.*

You may revoke consent to participate in the Pilot Program and/or to have information shared, as specified in this form, at any time by contacting the care management team at the Member's Health Plan. If consent is revoked, the Member will not be able to continue to receive Pilot services. This will not affect the Member's rights under their Health Plan to receive treatment, services, or benefits outside of the Pilot program. Unless revoked, this consent will end on April 30, 2025. If consent is revoked, no additional information about the Member will be shared. However, information previously shared while consent was in place will still be used for the Pilot evaluation.

If the Member, Legal Guardian, or the Authorized Representative is completing this form in person or electronically, please sign and date in #1 below.

1. **Member, Legal Guardian, or Authorized Representative Signature**

Member, Legal Guardian, or Authorized Representative Name

Member, Legal Guardian, or Authorized Representative Signature Date

Relationship to Member

If the form is being completed and consent obtained telephonically or virtually, the Care Manager should read the entire form to the Member, Legal Guardian, or Authorized Representative and complete the information in #2 below.

2. **Care Management Team Member Signature** *(for use only when verbal consent is being obtained telephonically or virtually by a member of the Care Management team)*

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I, _____ (Name of Care Manager), on _____ (Date) read and discussed the information provided in this form with the member, legal guardian, or authorized representative specified above. Further, on _____ (Month/Day/Year) at _____ (Time) the member, legal guardian, or authorized representative specified above provided verbal consent to record their responses to questions on the form.

I have accurately recorded the responses to the questions in this form provided to me by the member, legal guardian, or authorized representative specified above.

_____ _____

Care Manager Signature Date