☐ Section E Language

What is your Language?: _____

☐ I cannot speak about my medical needs in English.

☐ I cannot find any Medicaid health plan doctor whom I can speak with about my medical needs in my language.

Other family members who have a language reason not to join a health plan:

Name:	ID #: *(NYS Benefit Card)*	Name:	ID #: *(NYS Benefit Card)*
Name:	ID #: *(NYS Benefit Card)*	Name:	ID #: *(NYS Benefit Card)*

☐ I need more space to list my family members. *(New York Medicaid CHOICE will contact you for the names.)*

I hereby certify that I speak the applicant's primary language, which is other than English, or that I have a staff person capable of translating medical terminology in the applicant's language, which is other than English.

I further certify that I am a fee-for-service provider in the Medicaid program. I do not participate in any of the managed care plans under contract with the Medicaid program.

Health Care Provider: Complete and sign.

Date: (mm/dd/yy) Provider/Physician*: License #:

Specialty: MMIS Provider ID #:

Office/Clinic Address:

City: Zip Code: Phone: ( ) Fax: ( )

Signature:

* ***Must be signed by an Attending Physician.***

Information provided in this form is subject to verification by the New York State Department of Health; HRA, the LDSS, or New York Medicaid CHOICE.

☐ Section F Living Outside Your County for a Short Time Only

You must send some official paper showing that you are temporarily living outside the County where you receive Medicaid. For example, you can send a letter from your child's school saying that your child is a student there.

Your current temporary (short term) address:

Zip Code: How long you will be at this address:

Other family members who are temporarily living outside the County with you:

Name:	ID #: *(NYS Benefit Card)*	Name:	ID #: *(NYS Benefit Card)*
Name:	ID #: *(NYS Benefit Card)*	Name:	ID #: *(NYS Benefit Card)*

☐ I need more space to list my family members. *(New York Medicaid CHOICE will contact you for the names.)*

☐ Section G Native Americans

Please provide a copy of official documentation of your Native American status and other family members who are Native Americans living with you who do not want to join a health plan.

See Instructions Sheet for more details.

If the information disclosed involves the release of HIV/AIDS diagnosis then the **New York Medicaid CHOICE** staff should please note the following: This information has been disclosed to you from confidential records information, with specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure. The information provided is also subject to the confidentiality requirements of applicable federal and state laws including New York Mental Hygiene Law §§ 33.13 and 33.16.

REQUEST FOR EXEMPTION

New York Medicaid CHOICE
1-800-505-5678
TTY/TDD: 1-888-329-1541

Section A *Everyone Must Fill And Sign This Section*

I understand the following:

- I am asking for an exemption from the New York Medicaid CHOICE program. I do not want to join a health plan.
- I know that to ask for the exemption, I may need to give information about my medical condition. I give my Provider permission to give New York Medicaid CHOICE all needed medical information only if it is relevant to my request for the exemption. This may include mental health, HIV, alcohol or substance abuse, or disability information, if it is needed for this exemption request.
- I know that if I am now in a Medicaid health plan and I am approved for an exemption, I will be disenrolled from that health plan.

Name (Please Print):

Signature: (Head of Household must sign for person under 18) **Date:**

Home Telephone # (Area Code) **Cell Phone #** (Area Code)

Fill out any of the following Sections that apply to you.

☐ Section B No Medicaid Health Plan Doctor Near Your Home

There are no Medicaid health plan doctors within 30 minutes or 30 miles of your home.

The names of the 2 streets that cross each other nearest you: and

Address of your current doctor (or clinic):

☐ I need space to list my family members (New York Medicaid CHOICE will contact you).

☐ Section C Foster Care Children

Does not apply to all counties (Call the HelpLine to learn if this exemption applies to your county).

You must sign and return this form along with a letter from the foster care agency.

☐ Section D Medical/Health

Health Care Provider/Professional: Complete 1, 2, 3 or 4, as applicable. You must also complete and sign Box 9. By completing and signing this form you are attesting that you do not participate with any of the Medicaid managed care plans but you do participate with fee-for-service Medicaid.

1. I provide prenatal care to this patient and ***I do not participate*** in a Medicaid health plan.

Date (mm/dd/yy) of patient's last visit: _____ Due date (mm/dd/yy) (EDC): _____

2. I provide medical care to this patient who is scheduled for surgery within 30 days after managed care enrollment and ***I do not participate*** in a Medicaid health plan.

Date (mm/dd/yy) of patient's last visit : _____ Surgery date (mm/dd/yy): _____

Patient's condition(s) / diagnosis(es): _____

Surgery to be performed: _____

3. ☐ I have been this patient's **primary care provider** for at least one year and ***I do not participate*** in a Medicaid health plan. **Note:** PCP must check box and complete #9.

4. I am a **specialist** practicing one or more of the medical specialties listed below and providing care to this patient for at least six months and ***I do not participate*** in a Medicaid health plan.

Patient's condition(s) / diagnosis(es): _____

I have been providing care since Date (mm/dd/yy): _____ Patient's last visit Date (mm/dd/yy): _____ Completion of treatment if applicable, Estimated Date (mm/dd/yy): _____

List of Medical Specialties

- Allergy and Immunology
- Cardiology
- Endocrinology
- ENT Surgery
- Gastroenterology
- Hematology
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Psychiatry
- Physiatry (Rehabilitative Medicine)
- Plastic Surgery (non-cosmetic)
- Pulmonology
- Rheumatology
- Other *(as approved by NYSDOH)*

☐ Section D Medical/Health (continued)

Health Care Provider/Professional: Complete 5, 6, 7 or 8, as applicable. You must also complete and sign Box 9.

5. I provide medical care to the person requesting an exemption and my patient has *(check one)*:

- ☐ End-stage renal disease (ESRD)
- ☐ HIV/AIDS *(**Note:** Doctors and providers should call 1-888-9EXEMPT to learn if this exemption reason applies to your patient).*

6. The patient needs care in the home or in the community as the result of a physical or developmental disability. (A developmental disability occurs before age 22 and has substantial lifelong functional impairments.) The patient receives coordinated care/services intended to address health care needs, severe behavior problems and/or adaptive behavior deficits. **Note:** A physician, or in the case of developmental disabilities, a Qualified Mental Retardation Professional must check box and complete #9.

☐ My patient's care meets ALL of the following criteria:

- The patient requires extensive and/or complex care in their home or community for at least 120 days; and
- This care allows the patient to stay in their home or in the community in lieu of being in an institutional setting (such as a permanent or long-term placement in a nursing home, intermediate care facility, hospital or skilled nursing facility); and
- A physician and/or qualified health professional has ordered these services

7. My patient is a resident of *(name facility)* _____

☐ an intermediate care facility for the mentally retarded and is expected to stay from: _____ (Date (mm/dd/yy)) until: _____ (Date (mm/dd/yy))

8. I am a psychiatrist, psychologist or LCSW. My patient is an adult who is seriously and persistently mentally ill, or a child who is seriously emotionally disturbed. She/he does not have SSI, nor is certified blind or disabled. My patient has utilized the services that I have checked below during the last 12 months.

- ☐ Ten or more encounters, including visits to a mental health clinic, psychiatrist or psychologist, and inpatient hospital days relating to a psychiatric diagnosis; **or**
- ☐ One or more specialty mental health visits (i.e., psychiatric rehabilitation treatment program; day treatment; continuing day treatment; comprehensive case management; partial hospitalization; rehabilitation services provided to residents of OMH licensed community residents and family based treatment; and mental health clinics for seriously emotionally disturbed children).

9. Provider Information/Signature (Must be completed)

Date: _____ (mm/dd/yy) Provider/Physician*: _____ (Please Print) License #: _____

Specialty: _____ MMIS Provider ID #: _____

Name of (Clinic/Facility): _____

Address: _____

City: _____ Zip Code: _____ Phone: ( ) _____ Fax: ( ) _____

Signature: _____

**** Must be signed by an Attending Physician, or by a Qualified Mental Retardation Professional for Section D.6.***

Information provided in this form is subject to verification by the New York State Department of Health; HRA, the LDSS, or New York Medicaid CHOICE.