VNSNY CHOICE MLTC
Enrollment Application and Agreement

CHOICE Health Plans

By completing and submitting this information, you will apply for membership in VNSNY CHOICE Managed Long Term Care and agree to plan policies. Questions filling out the form? Please call Member Services at 1-855-867-6555 (TTY: 711) 9 am – 5 pm, Monday – Friday.

Your information

Last Name _____ **First Name** _____ **Middle Initial** _____

Address _____ **Apt #** _____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

City _____ **State** _____ **Zip Code** _____ **Area Code and Telephone #** _____

Medicaid # _____ **Social Security #** _____ **Date of Birth (MM-DD-Year)** _____

Medicare # _____ **Medicare Effective Date** _____

Medicare Coverage
☐ Part A ☐ Part B

Medicare HMO
☐ Yes ☐ No

If Yes, Name of Company _____

Your agreement to enroll in VNSNY CHOICE MLTC

I hereby agree to enroll in VNSNY CHOICE MLTC (The Plan). I have met with The Plan nurse, and she/he has fully explained to me the program's services and procedures. This includes:

☐ I have received a Member Handbook from The Plan, which describes the program's covered services, policies, and procedures. As a VNSNY CHOICE MLTC member, I agree to follow the terms and conditions described in the Member Handbook.

☐ I agree to obtain all covered services from The Plan and its network of providers and I have received a Provider Directory.

☐ If I have a Medicaid surplus, I agree to pay this amount to VNSNY CHOICE MLTC.

☐ As a member of The Plan, I retain my right to choose a primary care physician.

☐ 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 The Plan to help me return to community living.

I understand the following. My enrollment in the program is voluntary. New York Medicaid Choice must approve my enrollment. Once my enrollment is approved, my coverage will begin on the first day of the next month. I have the right to disenroll (leave the plan) at any time, as long as I let the plan know orally or in writing. My disenrollment will take effect on the first day of the month following the month in which the disenrollment is processed.

Date:

I understand that my date of enrollment is expected to be: _____

For applicants who do not speak English as a first language

Name

I, _____, have been provided with a copy of this

Preferred Language

enrollment agreement/attestation in my primary language of _____

Your signature or the person authorized to sign for you

All information provided above is true and complete to the best of my knowledge.

Signature of Applicant

_____

Signature of Person Authorized to Sign for Member if Applicant is Unable to Sign

_____

Date Signed by Applicant or Authorized Person

_____

Relationship to Applicant

_____