Frequently Asked Questions about Consent to Case Management Paperwork

Why do I need to sign this paperwork?
We're asking you to review and sign this Consent to Case Management document before Case Management begins because we need to comply with state and federal regulations. You are only agreeing to be treated for the condition you initial next to at the bottom of the form.

Do I still need to sign even if I don't have all of the health conditions listed in the document?
Yes. Signing this paper only means you are agreeing to treatment for your specific diagnosis. It does not mean you will be treated for the other conditions listed that do not apply to your situation.

What if my child is the one receiving treatment?
If your child is less than 18 years old, then you can sign on behalf of your child and access the diagnosis and treatment information until your child turns 18 years old – unless your child is being treated for one or more of the following: sexually transmitted diseases, abortion, HIV/AIDS or substance use disorder(s).

What happens if my child is being treated for sexually transmitted diseases, abortion, HIV/AIDS or substance use disorder(s)?
In that case, your child will need to sign this paperwork consenting to treatment – even if they are under the age of 18. This is because state and federal regulations require the individual to consent to their own care regardless of age. It also means your child will need to give you permission to access their diagnosis or treatment information.

How can my child give me permission to see their information?
It's important to understand that it is your child's choice about whether they give permission for you or anyone else to see their case management information. Your child's decision does not affect the care they receive.

- **Children who are older than 18 years old:** Your child will need to fill out the Authorization to Disclose Protected Health Information (PHI) form before information can be released to you or anyone else. Search for "Manage your Privacy" at www.univerahealthcare.com to find the form.
- **Children who are being treated for HIV/AIDS:** NY State has different rules about releasing health information for HIV/AIDS. For your child to share information related to their HIV/AIDS treatment, no matter how old they are, the child must sign the New York State "Authorization for Release of Health Information and Confidential HIV Related Information (DOH-2557)" before we can share any information about their case management with you or anyone else. That form is available at: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm

Is there anything else I need to know about Substance Use Disorder Regulation?
Pursuant to 42 CFR Part 2, any substance use disorder information from a Part 2 Program relating to these case management services will only be used or released in accordance with a written consent to release, or as permitted under applicable law(s) and members have a right to obtain a list of disclosures as described in Section II, Part D below.

univera HEALTHCARE

CASE MANAGEMENT PROGRAM CONSENT

For Internal Use

Member Information:				
LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)

CURRENT ADDRESS	CITY	STATE/ZIP CODE	PHONE NUMBER

Section I: Case Management Consent

I agree to participate in the case management program administered by Univera Healthcare or its contracted agency (Health Plan) for the condition(s) initialed below. This is a collaborative process between myself, my Health Plan care manager and my health care team. Case Management services may include general health education, coordination of care with my health care team, and referrals to appropriate community resources. By agreeing to participate and by signing below:

1. I consent to and agree that I can be contacted by telephone at the number(s) provided, in writing, or in person by the Health Plan care manager(s) for case management of my health condition(s).
2. I understand that:
    - The case management program is voluntary, except where otherwise required under my contract benefits, and when voluntary, I may withdraw from the program at any time by notifying the Health Plan either verbally or in writing.
    - This consent to case management is not a condition for receiving care or treatment by my physician or coverage by the health plan, except where otherwise required under my contract benefits.
    - This consent is to remain in effect as long as I remain in the case management program. I can revoke this consent at any time by notifying the Health Plan either verbally or in writing (when required) except this revocation would not affect any action taken by the Health Plan in reliance on this consent before my revocation is received.
    - I will follow the contractual provisions of my health insurance contract and the case management program policies and guidelines of the Health Plan.
    - As permissible under state and federal laws, the Health Plan may use my personal health information (PHI) in its possession to help provide case management resources and services to me.
    - Any information I share as part of the Health Plan's case management program can be shared with any other entity that is involved in and helps manage my care.
3. If the case management program I am receiving includes the ability to have in-person meetings, I understand that agreeing to any in-person meeting in a public place (such as a coffee shop, library or shared household), means there are risks associated. This means that some people may overhear us talking about my health information.

Section II: Consent to Case Management of Specific Conditions (PLEASE READ AND INITIAL, if applicable)

By placing my initials next to one or more of the conditions below, I am agreeing to participate in the case management program for **only** those conditions. I will **not** receive case management for any item I do not initial next to. If at any time I would also like case management services for a condition I did not initial below, an additional form needs to be completed.

_____ Mental Health **_____ HIV/AIDs** **_____ Substance Use** *(Please see Section III)*

Continued on reverse

Section III: Consent to Release of Substance Use Information (applicable if Substance Use initialed above)

Part A: PERSON(S) PERMITTED TO MAKE DISCLOSURES

1. Excellus Health Plan, Inc. d/b/a Univera Healthcare ("Health Plan").
2. Any health care provider that has treated me in the past, is treating me now, or treats me in the future ("Provider").

Part B: RECIPIENT OF AND PURPOSE OF DISCLOSURE

1. Provider may disclose Patient Identifying Information (PII) to Health Plan to conduct case management and care-coordination activities.
2. Health Plan may disclose PII to Provider for case management and care coordination activities.
3. Health Plan may disclose PII to other third parties involved in your case management or care-coordination activities, as permitted under applicable laws.

Part C: INFORMATION TO BE DISCLOSED

All information necessary for case management and care coordination of Substance Use Disorder(s). This may include (among other information) diagnoses (names of illnesses or conditions), procedures (type of treatments), dates of treatment, and names of health care practitioners or other providers.

Part D: DISCLOSURE ACCOUNTING

Health Plan is required to provide you (or your authorized representative) a list of persons or entities to which the Health Plan re-discloses your Patient Identifying Information pursuant to this consent in accordance with the requirements of the Confidentiality of Substance Use Disorder Patient Records Rule. The list may be limited to disclosures made in the two years immediately preceding your request. You may request a list of disclosures in writing. Request can be sent to: Corporate Privacy Office, P.O. Box 4809, Syracuse, NY 13221-9987.

Part E: EXPIRATION OR REVOCATION OF CONSENT

This consent for disclosure will expire one-year after you disenroll from the Health Plan. You may revoke this consent at any time by writing the Health Plan at the address provided below. Your revocation will not be effective, however, to the extent that Health Plan, or any Provider has acted in reliance on the consent.

Section IV: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

IMPORTANT: I have read the contents of this form. I hereby consent to participate in the case management program administered by the Health Plan for the condition(s) I've initialed in Section II above. I agree to allow the disclosures of my information as described above.

Signature: _____Date: _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature: _____ Date: _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

* You must provide documentation supporting your legal authority to act on behalf of the member

PLEASE RETURN THIS COMPLETED FORM TO:

P.O. Box 21146
Eagan, MN 55121
Or Fax: 1-877-243-6819

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS