**WISCONSIN DEPARTMENT OF HEALTH SERVICES**

Division of Public Health

F-00533LP (02/2024)

**PARTNERSHIP PROGRAM ENROLLMENT**

**INSTRUCTIONS AND IMPORTANT INFORMATION**

Completion of this form is voluntary; however, this form must be completed if you are interested in enrolling in the Partnership program. If you want to apply for the Partnership program, you must contact your local Aging and Disability Resource Center (ADRC). If you are a member of the Menomonie, Oneida, Lac du Flambeau, or Sokaogon Tribe you may also contact your tribal aging and disability resource specialist (ADRS). Contact information for local ADRCs or Tribal ADRS can be found at [www.dhs.wisconsin.gov/adrc/consumer/index.htm](https://www.dhs.wisconsin.gov/adrc/consumer/index.htm)

**HOW TO USE THIS FORM**

1. Read the Important Information section and all the instructions before signing the form. If you need information in another language or format, please contact your local ADRC or Tribal ADRS.
2. Only the individual, his or her legal guardian, conservator, or his or her activated power of attorney, can sign this form.

**IMPORTANT INFORMATION**

* Signing this form does not guarantee you will be eligible for the Partnership program.
* If you are eligible, you will be able to choose among the Partnership programs available in your area.
* After you sign this form, you can choose not to enroll.
* Enrollment in Partnership is voluntary and you may disenroll at any time, however your Medicare benefits will remain with that plan until you are eligible to change your Medicare plan.
* Changes in your health or financial situation may affect your eligibility for the Partnership program. If such a change occurs, talk with your Partnership Organization (PO) care manager or Tribal case manager, if applicable.

**SIGNING THIS FORM**

I understand that my signature (or the signature of my legal guardian, conservator or activated power of attorney) on this form means I have read and understand the contents of this form, including information about date of enrollment and assurance of choice below. I certify that all my answers are complete to the best of my knowledge. I understand that if I intentionally hide information or provide false information on this form, I may be disenrolled from the program. I understand that my signature authorizes the ADRC or Tribal ADRS to release my information to:

* The Managed Care Organization
* Another ADRC or Tribal ADRS
* Income Maintenance agencies
* The tribe of affiliation, if provided
* Medicaid
* Medicare
* Service providers and their authorized representatives for the purpose of providing my care.

**REQUESTED DATE OF ENROLLMENT**

You may choose the date you would like to enroll in the program. However, enrollment cannot occur before the date:

* The ADRC or Tribal ADRS receives this signed form.
* You meet all functional and financial eligibility requirements.

**ASSURANCE OF CHOICE**

The primary purpose of the Partnership Program is to help you get the services you need to live in your own home or community whenever possible.

**PERSONAL INFORMATION**

Under Wis. Stat. § 49.45(4), your personally identifiable information is kept confidential and is only used for the direct administration of the Partnership program.

**INFORMATION REGARDING PARTNERSHIP**

Partnership is a Wisconsin Medicaid and Medicare managed care program and certain eligibility requirements apply. If you are entitled to Medicare, you must enroll in all parts of Medicare for which you are eligible including Medicare Part D Prescription Drugs.

If you are currently enrolled in Medicare, your current plan will continue to provide your Medicare benefits until you become eligible to enroll in the Partnership Medicare plan.

To enroll in Partnership, you must live in a Partnership organization’s service area, must be at least 18 years old in the month of enrollment, require a nursing home level of care, and be eligible for Medicaid.

**ADDITIONAL INSTRUCTIONS**

**Section I**

* “County of Residence” means the county in which you physically live.
* “County of Responsibility” means the county that has responsibility to provide mental health or other services.
* “Permanent Street Address” means the address of the residence in which you physically live.

**Section II**

 This section will be completed if you have a legal guardian, conservator, activated power of attorney, or Medicaid authorized representative.

**Section III**

Please provide emergency contact information of a friend or relative whom we can contact in case of an emergency.

**Section IV**

This section will be completed if applicable.

**Section V**

This section will be completed if you want any applicable Medicare Part D drug plan premium deducted automatically from your Social Security.

**Section VI**

Your signature or the signature of your legal guardian, conservator, or your activated power of attorney is required. If you sign with a mark, two witness signatures are required. If you are physically unable to sign, you may direct an adult to sign the form in front of two witnesses. The person who signs on your behalf should indicate that he or she is signing at the direction of the applicant.

The ADRC or Tribal ADRS must retain the originally signed enrollment form, or an electronically scanned copy of the signed form, for ten years in the event of a records request.

**PARTNERSHIP PROGRAM – ENROLLMENT**

**CIP**

**INSTRUCTIONS**: Before signing this form, read all instructions.

|  |
| --- |
| **SECTION I –PERSONAL INFORMATION** |
| Member Name (First, MI, Last)      | Date of Birth      |
| Sex[ ]  Male[ ]  Female | Current Marital Status (Check one box only)[ ]  Single [ ]  Married [ ]  Widowed | If Currently Married, Name of Spouse(First, MI, Last)      |
| Mailing Address      | City      | State     | Zip Code      |
| Phone Number      | County of Residence      | County of Responsibility      |
| American Indian/Alaskan Native[ ]  Yes [ ]  No | American Indian/Alaskan Native Affiliation      |
| Email Address      |
| Permanent Street Address(If different than above)      | City      | State     | Zip Code      |
| Facility Name—Check Type: [ ]  NH [ ]  ICF-IID[ ]  CBRF [ ]  AFH [ ]  RCAC      | Date of NH or ICF-IID Admission      |
| Facility Street Address(If different from above)      | City      | State     | Zip Code      |
| **SECTION II – ALTERNATIVE ENROLLMENT AUTHORITY** |
| Do you have a Legal Guardian? [ ]  Yes [ ]  NoType: [ ]  Guardian of Person [ ]  Guardian of Estate [ ]  Guardian of Person and Estate |
| Name of Guardian (First, MI, Last)      | Phone Number      | County of Residence      |
| Mailing Address (street, city, state, zip code)      |
| Do you have another Legal Guardian? [ ]  Yes [ ]  NoType: [ ]  Guardian of Person [ ]  Guardian of Estate [ ]  Guardian of Person and Estate |
| Name of Guardian (First, MI, Last)      | Phone Number      | County of Residence      |
| Mailing Address (street, city, state, zip code)      |
| Do you have an Activated Power of Attorney for Finance and Property (POAF)? [ ]  Yes [ ]  No |
| Name of POAF (First, MI, Last)      | Phone Number      | County of Residence      |
| Mailing Address (street, city, state, zip code)      |
| Do you have an Activated Power of Attorney for Health Care (POAHC)?[ ]  Yes—Date Activated:       [ ]  No |
| Name of POAHC (First, MI, Last)      | Phone Number      | County of Residence      |
| Mailing Address (street, city, state, zip code)      |
| Do you have a Conservator? [ ]  Yes—Date conservator ordered       [ ]  No |
| Name of Conservator (First, MI, Last)      | Phone Number      | County of Residence      |
| Mailing Address (street, city, state, zip code)      |
| **SECTION III –ADDITIONAL CONTACT INFORMATION** |
| List the name of a friend or relative whom we can contact in case of an emergency.      |
| Name of Contact (First, MI, Last)      | Daytime Phone Number      | Evening Phone Number       | Relationship to You      |
| Do you have a Medicaid Authorized Representative as Designated on DHSform [F‑10126A](https://www.dhs.wisconsin.gov/forms/f10126a.pdf) or [F‑10126B](https://www.dhs.wisconsin.gov/forms/f10126b.pdf)? [ ]  Yes—Date:       [ ]  No |
| Name of Medicaid Authorized Representative (First, MI, Last)      | Phone Number      | County of Residence      |
| Mailing Address (street, city, state, zip code)      |
| **SECTION IV – INSURANCE INFORMATION** |
| Do you currently have medical/health insurance coverage such as employer-provided health insurance, private insurance, VA benefits, TRICARE or federal employee health benefits coverage?[ ]  Yes [ ]  No |
| Name and Address of Insurance Company      | Policy or Identification Number      |
| Group Number      |
| Do you currently have prescription drug coverage? [ ]  Yes [ ]  No |
| Name of Coverage      | Policy or Identification Number      | Group Number      |
| Do you receive Social Security Benefits? [ ]  Yes [ ]  No |
| Do you receive Railroad Retirement Board (RRB)? [ ]  Yes [ ]  No |
| **If you are eligible for Medicare**: | Is Entitled To: |
| Beneficiary Name (First, MI, Last):        | Effective Date: (mm/dd/yyyy) |
| Medicare Beneficiary Identifier (MBI):        | **HOSPITAL (PART A)**       |
|  | **MEDICAL (PART B)**       |
| **Please Read This Important Information** |
| **If you currently have health coverage from an employer or union, joining Partnership could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Partnership.** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If you don’t know who to contact, your benefits administrator or the office that answers questions about your coverage can help. |
| **SECTION V – MEDICARE PART D PRESCRIPTION DRUG PLAN PREMIUM AND ESRD** |
| Most qualify for extra help with Medicare prescription drug coverage costs. Medicare may cover all or some portion of your plan premium. If applicable, you can have the monthly premium for this Medicare Advantage plan automatically deducted from your Social Security check. If you do not choose this option, the Partnership plan will send you a bill each month that you can pay by mail or by electronic funds transfer (EFT).I want the premium for this plan deducted from my monthly benefit check from theSocial Security Administration (SSA): [ ]  Yes [ ]  No |
| **SECTION VI – ENROLLMENT CHOICE AND SIGNATURE** |
| **Read and Sign Below** |
| Requested Date of Medicaid Enrollment:        |
| Partnership Plan Selected:[ ]  My Choice Wisconsin Health Plan, Inc.[ ]  Community Care Health Plan, Inc.[ ]  Independent Care Health Plan |
| **By completing this enrollment application, I agree to the following:**A Partnership Plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. I will continue to receive my Medicare benefits from my current Medicare plan until I am eligible to change Medicare plans. Enrollment in a Medicare plan is generally for the entire year. Once I enroll, I may leave a Medicare plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. The selected plan serves a specific service area. If I move out of the area that the selected plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of the selected plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Partnership Evidence of Coverage document and Enrollment Agreement from the selected plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage or Medicare plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date the selected plan coverage begins; I must get all of my health care from the selected plan except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the selected plan and other services contained in my selected plan’s Partnership Evidence of Coverage document and Enrollment Agreement will be covered. **WITHOUT AUTHORIZATION,** **NEITHER MEDICARE NOR THE SELECTED PLAN WILL PAY FOR THE SERVICES.****Release of Information:** By joining this Medicare health plan, I acknowledge that the selected plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the selected plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that (1) this person is authorized under state law to complete this enrollment and (2) documentation of this authority is available upon request by the selected plan or by Medicare.I, the undersigned, do hereby state my intent, and do hereby agree, to enroll into the Partnership Program identified above. I understand that my Medicaid enrollment start date will be       and my Medicare enrollment will start the first of the month following submission of this form if I qualify for a Special Election Period. I will continue to receive my Medicare benefits from my current plan until I am eligible to enroll into the Partnership plan I have selected above. |
| **I, the undersigned, do hereby state my intent and do hereby agree to enroll into the Partnership Program identified above.** |
| **SIGNATURE –** Individual | Date Signed |
|  |  |
| **SIGNATURE –**  Legal Guardian, Conservator, or Activated Power of Attorney | Date Signed |
|  |  |
| **SIGNATURE –**  Legal Guardian, Conservator, or Activated Power of Attorney | Date Signed |
|  |  |
| **SIGNATURE** – Witness (if applicable) | Date Signed |
|  |  |
| **SIGNATURE** – Witness (if applicable) | Date Signed |
|  |  |
| **For ADRC OR Tribal ADRS Office Use Only** |
| ADRC or Tribe:       | County:       |
| ADRC or Tribal ADRS Worker:       | Phone Number:       |
| Email Address:       |
| Enrollment Date Information:Actual Date of Enrollment:     [ ]  Enrollment date pending: Urgent Services[ ]  Enrollment date pending: Pre-Release Agreement[ ]  Enrollment date pending: Transfer to new agency with move. | Program:[ ]  Partnership | Verify HMO End Date if applicable:      |
| Enrollment Status in FHiC:[ ]  Enrollment date entered in FHiC[ ]  Enrollment date not entered in FHiC: pending MA or IRIS entry in system. PO does not update LTCFS until enrollment is verified in FHiC. |  |  |
| Medicaid Recipient [ ]  Yes [ ]  NoMedicaid ID No:      Language for CARES Notice:[ ]  English [ ]  Spanish | Level of Care [ ]  ICF (intermediate Care Facility)[ ]  SNF (Skilled Nursing Facility)[ ]  ISN (Intensive Skilled Nursing | Target Group:[ ]  FE[ ]  ID/DD[ ]  PD  |
| [ ]  Person is currently enrolled in Children’s Waiver (CLTS) |
| Name – CLTS Worker      | County      |
| Phone Number      | Email Address      |
| **Partnership Office Use Only**Plan ID Number:       | Name of Staff Member (if assisted in enrollment)      |
| Medicare Election Period:[ ]  ICEP or IEP [ ]  OEPI [ ]  AEP [ ]  SEP (Type):       |
| Effective Date of Medicare Coverage      | Medicaid Provider No.      | Actual Date of Medicaid Enrollment      |

Distribution of completed form: [ ]  Individual, Guardian, Conservator, or Activated Power of Attorney

[ ]  Selected Partnership Organization

[ ]  Income Maintenance

[ ]  Tribe if applicable

[ ]  CLTS Worker if applicable