14 Penn Plaza
2nd Floor
New York, NY 10122
1-800-556-0689, TTY 711

Date

Name
Address
City, State Zip Code

ELECTRONIC NOTICE OPTION LETTER

Dear [Enrollee]:

This is an important letter about notices you get from Amida Care. Please read it carefully.

Why am I getting this letter?

You are getting this letter because you can now ask Amida Care to send you certain notices electronically.

What notices can I get electronically?

Notices about:

- Services you asked for
- Services you are getting *or* will get
- Plan appeals
- Complaints; and
- Complaint appeals

These notices have important information about your services and rights.

Who gets these notices?

You and your provider get these notices. You can also choose someone to represent you, like a family member, friend, or lawyer. The person you choose will be able to file a complaint, plan appeal or fair hearing for you. We also send them a copy of your notices.

If you told us before that someone may represent you, we will send that person a letter like this one. If you want someone new to represent you, you and that person must sign and date a statement saying this is what you want. The person you choose can get copies of your notices electronically if they ask. We will send their notices as required by law. If you have any questions about choosing someone to act for you, call us at: **1-800-556-0689**, **TTY 711**.

What ways can these notices be sent?

You can access these notices by Web Portal. Your notices will be available in the **My Amida Care App.** You can see these notices in the app by clicking on the ***E-Notices*** button. You will get an email alert when a notice is posted on the portal. You can review the My Amida Care App FAQ's (Frequently Ask Questions) included with this letter. You can also visit our website at **https://www.amidacareny.org/my-amida-care-faqs/**.

Please note that standard data rates may apply when you access an email or go to our web portal.

To get more information or help, visit our website at www.amidacareny.org or call Member Services at **1-800-556-0689, TTY 711**.

How do I ask for electronic notices?

- You can contact us by phone to tell us you want to receive electronic notices, by calling us at 1-800-556-0689, TTY 711.
- You can email us at member-services@amidacareny.org to let us know you want to receive electronic notices.
- You can contact us on our website if you would like to receive electronic notices. First visit our *How to Reach Us* page at **https://www.amidacareny.org/how-to-reach-us/**. Then select Current Members and click on the Email Us link.
- You can contact us by fax to tell us you want to receive electronic notices. Send a fax to 1-646-786-1837.
- You could also mail a completed Electronic Notice Request form to us, using the enclosed envelope or email the form to us at member-services@amidacareny.org. The Electronic Notice Request form is attached, included with this letter.
- You could also write to us to let us know you would like to receive electronic notifications by sending your request to Amida Care PO Box 18023 Hauppauge, NY 11788.

When you contact us to let us know you want to receive electronic notifications, you must tell us:

- how you want to get notices that are normally sent by mail,
- how you want to get notices that are normally made by phone call, and
- your contact information (mobile phone number, email address, fax number, etc.).

You can **select or change** the way you get your notices at any time. A Member Services representative can help you change the way you get notices when you call us at **1-800-556-0689, TTY 711.**

If your contact information changes, **you must let us know**. To change your information, contact Member Services at **1-800-556-0689, TTY 711**.

What happens next?

Amida Care will let you know by mail that you have asked to get notices electronically.

If you ask to get your notices electronically:

- Your notices will be available within the **My Amida Care App**. We will send you an email whenever a notice is posted to the app.
  - You will be able to view, print and save these notices within the My Amida Care app.
  - Your notices will be available for up to 1 year.
  - If you leave Amida Care, your notices will be available for 120 days from the date you leave.
- You can still ask us to send any of your notices by mail. We will send your notice by mail within 2 working days from the day you asked.
- You can still ask us to send any of your notices in an alternate format to accommodate a disability or language need. We will send your notice within 5 working days from the day you asked. In some cases, it may take us up to 30 days from the date of your request. In those cases, we will call you to help.

If you ask to get notices electronically and we believe the electronic notice did not go through, we will then send it by mail and we may also call you by phone, as required by law.

Can I change the way I get these notices later?

You can change the way you get your notices at any time. To change the way you get notices, you can contact us via phone, email, online, fax or mail. Our contact information is listed above in the *How do I ask for electronic notices* section of this letter.

If you ask for a change via phone, email, online or fax we have 5 working days from the date we got your request to make the change. If you ask for a change by mail, we have 10 working days from the date we got your letter to make the change.

What If I don't want electronic notices?

You will keep getting these notices by mail and we may also call you by phone. We will not send these notices electronically unless you ask.

You can still ask us to send these notices in a different way because of a disability or language need.

Amida Care will not treat you differently if you do not want to get these notices electronically.

You can call Amida Care at **1-800-556-0689**, **TTY 711** if you have any questions about this notice.

Sincerely,

Member Services Department

Enclosure(s):
Electronic Notice Request Form
My Amida Care App FAQ'

Amida Care

NOTICE OF NON-DISCRIMINATION

Amida Care complies with Federal civil rights laws. Amida Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Amida Care provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Amida Care at 1-800-556-0689. For TTY/TDD services, call 711.

If you believe that Amida Care has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Amida Care by:

Mail:	14 Penn Plaza, 2nd Floor, New York, NY 10122
Phone:	1-800-556-0689 (for TTY/TDD services, call TTY 711)
Fax:	1-646-786-1802
In person:	234 West 35th St., New York, NY 10001
Email:	member-services@amidacareny.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-556-0689 TTY:711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-556-0689 TTY:711	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-556-0689 TTY:711.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-556-0689رقم هاتف الصم والبكTTY:711	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-800-556-0689 TTY:711 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-556-0689 TTY:711	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-556-0689 TTY:711	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-556-0689 TTY:711	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-556-0689 TTY:711	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט711:0689-556-800-1 TTY	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-556-0689 TTY:711	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-556-0689 TTY:711	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-800-556-0689 TTY:711	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-556-0689 TTY:711	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-556-0689 TTY:711.	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-556-0689 TTY:711.	Urdu

AMIDA CARE ELECTRONIC NOTICE REQUEST FORM

Name: [Enrollee Full Name]

Enrollee Number: [Member ID number]

Instructions: *Complete this form to ask AMIDA CARE to send your notices electronically. You **must** select an electronic option in #1 and #2 below. Incomplete forms cannot be processed. We will send you a confirmation letter in the mail if you choose to receive your notices electronically.

1. Instead of getting a notice by mail, I want AMIDA CARE to send me these notice by:

   ☐ **Web Portal**

2. If you told us you want to receive your mail notices electronically, Amida Care may still also call you by phone. If you do not want to continue to receive notices by phone, please let us know below:
   a. Instead of getting a notice by phone, I want AMIDA CARE to send me these notices by:

   ☐ **Web Portal**

***In order to receive Electronic Notifications from Amida Care you will need to join the MY AMIDA CARE APP! Please see FAQ attached on how to join or sign up at:**
www.amidacareny.org/for-members/my-amida-care/my-amida-care-form/

If you already have an My Amida Care App account, please enter your contact email below:

Email:_____

You must authorize this change by signing below:

Signature: _____ **Date**: _____

Consumer Directed Authorized Representative (Designee) Form

In connection with the care that you receive from Amida Care, you can choose someone to represent you and to assist with administrative tasks, like a family member, friend, or lawyer. If you want someone to represent you, this person would be your "designee." **Appointing a designee is voluntary and is not required**. If you appoint a designee, this person may take certain administrative actions related to your Medicaid coverage with Amida Care. Your designee will have access to your protected health information.

To appoint a designee, please complete the questions below:

Designee Information:

Name: _____

Address: _____ _____
Street Apt

_____ _____ _____
City State Zip

Phone #: ( ) _____ Email: _____

Designee Responsibilities:

Do you authorize this designee to receive all Health Care notices sent from Amida Care, including notices about the services you are trying to get and the services you are currently receiving? This information will contain your Protected Health Information and may include information about Alcohol/Drug treatment, Mental Health Information, Gender Identity or HIV-related information.	☐ YES	☐ NO
Do you authorize this designee to act for you in connection with any complaints, appeals or fair hearings, including receiving all notices related to such complaints, appeals or hearings? If yes, your designee will receive Protected Health Information related to any complaints, appeals or hearings.	☐ YES	☐ NO

If you answered "YES" to any of the designee responsibilities, please complete this form in its entirety.

Amida Care Member:

You attest that you have appointed the above-named individual as your designee to represent you as indicated in this form. If you selected that your designee may receive Health Care notices sent from Amida Care, Amida Care and our vendor partners (Healthplex, Carelon and Davis Vision) will send all notices to you and your designee about the services you are trying to get and the services you are currently receiving to your designee. Similarly, if you selected that your designee may represent you in connection with any complaints, appeals or hearings, Amida Care will send all related notices to you and your designee. You understand that this information will contain **Protected Health Information** and may include information about Alcohol/Drug treatment, Mental Health Information (except psychotherapy notes), Gender Identity, and/or confidential HIV-related information. You authorize Amida Care to provide this Protected Health Information to your designee for the purposes set forth in this form.

You understand that this designation will remain in effect until you change or discontinue it. You have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this form, by writing to Amida Care at:

***Amida Care,* PO Box 18023 Hauppauge, NY 11788**.

You can also let us know you want to revoke your designee authorization by sending us an email to**: member-services@amidacareny.org**

You authorize that health information regarding your care and treatment be released as set forth in this form. You also acknowledge that, if you have authorized any prior designees to act on your behalf with Amida Care, any such prior designation is revoked upon completion of this form.

Enrollee Name: _____

Amida Care ID #: _____ Date of Birth: _____

Last 4 digits of Social Security Number: _____

Enrollee Signature: _____ **Date**: _____

Designee:

By signing below, I, the named designee above, agree to maintain the confidentiality of any information provided to me by Amida Care regarding the named Amida Care member. I acknowledge that I am prohibited by law from redisclosing or sharing any information related to alcohol or drug treatment, mental health treatment, gender identity or HIV-related information without the consent of the named Amida Care member.

Designee Signature: _____ **Date**: _____

***Please return the completed form in the included self-addressed envelope or mail this form to us at: Amida Care,* PO Box 18023 Hauppauge, NY 11788 or fax to 1-646-786-1837.**