VillageCareMAX

MEMBER HANDBOOK

VillageCareMAX Managed Long-Term Care Plan

www.villagecaremax.org

WELCOME TO VillageCareMAX MANAGED LONG TERM CARE PLAN

Welcome to VillageCareMAX Managed Long Term Care (MLTC) plan. The MLTC plan is especially designed for people who have Medicaid and who need health and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits VillageCareMAX covers since you are enrolled in the plan. It also tells you how to request a service, file a complaint, or disenroll from VillageCareMAX. Please keep this handbook as a reference, it includes important information regarding VillageCareMAX and the advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

HELP FROM MEMBER SERVICES

You can call us at anytime, 24 hours a day seven days a week, at the Member Services number below.

There is someone to help you at Member Services:
7 days a week
8:00 am to 8:00 pm
Call 1-800-469-6292 (TTY: 711)
If you need help at other times, call us at the same number for on-call service.

If you need assistance in another language, VillageCareMAX will provide you with staff or translation services to communicate with you in the language you speak. You can get this information for free in other formats, such as large print, braille, or audio. Call 1-800-469-6292 (TTY: 711), during the hours of 8:00 am to 8:00 pm, 7 days a week.

ELIGIBILITY FOR ENROLLMENT IN THE MLTC PLAN

The MLTC plan is for people who have Medicaid. You are eligible to join the MLTC plan if you:

1) Are age 18 and older,
2) Reside in the plan's service area which is Bronx, Kings (Brooklyn), New York (Manhattan), Queens.
3) Have Medicaid,
4) Have Medicaid only or are aged 18-20 with both Medicaid and Medicare **and** are eligible for nursing home level of care,
5) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, ***and***
6) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the date of enrollment:
   a. Nursing services in the home
   b. Therapies in the home

c. Home health aide services
d. Personal care services in the home
e. Adult day health care,
f. Private duty nursing; or
g. Consumer Directed Personal Assistance Services

The coverage explained in this Handbook becomes effective on the date of your enrollment in VillageCareMAX MLTC plan. Enrollment in the MLTC plan is voluntary.

NEW YORK INDEPENDENT ASSESSOR - INITIAL ASSESSMENT PROCESS

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process. NYIA will start the expedited initial assessments at a later date. The initial assessment process includes completing the:

- ***Community Health Assessment (CHA)*:** The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care plan.
- ***Clinical appointment and Practitioner Order (PO)*:** The PO documents your clinical appointment and indicates that you:
  - have a need for help with daily activities, ***and***
  - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIA will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later.

VillageCareMAX will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care, and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to VillageCareMAX about whether the plan of care meets your needs.

Once NYIA completes the initial assessment steps and determines that you are eligible for Medicaid Managed Long Term Care, you then choose which Managed Long Term Care plan to enroll with.

VillageCareMAX processes requests for enrollment in the order in which they are received. Enrolling in VillageCareMAX is easy. You or your family/caregiver or another person who helps you obtain services may contact VillageCareMAX by phone. A VillageCareMAX representative will talk to you and explain the program. He/she will determine that you meet age requirements, reside in our service area, and have Medicaid benefits. If you don't already have Medicaid but are interested in applying for Medicaid benefits, our staff can also help you with your Medicaid application.

Our staff can help you each step of the way, as outlined below.

You can call VillageCareMAX at 1-800-469-6292. TTY users should call 711. Our hours are 8:00 am to 8:00 pm, 7 days a week. We will talk to you about your health needs, benefits, and the enrollment process.

If you are new to Community Based Long Term Care Services, we will put you in touch with the New York Independent Assessor (NYIA). You may also call NYIA at 1-855-222-8350. The hours are Monday through Friday, from 8:30 am to 8:00 pm; and Saturday & Sunday from 10:00 am to 6:00 pm.

If you are transferring from another Managed Long Term Care Plan (MLTC) we will put you in touch with the State's enrollment broker (New York Medicaid Choice). You may also call them at **1-888-401-6582. TTY users should call 1-888-329-1541.** The hours are Monday through Friday, from 8:30 am to 8:00 pm; and Saturday from 10:00 am to 6:00 pm.

How do I enroll?
Once the above is complete, VillageCareMAX will use your assessment and any other medical documentation to help determine your needs for Long Term Services and Supports (LTSS). Your initial plan of care will be created, which will propose services, frequency and hours based on your needs. If you agree to the initial plan of care developed for you, we will proceed with the enrollment process.

Your enrollment will be submitted to New York Medicaid Choice (NYMC), the State's Enrollment Broker. They are responsible for processing all enrollments.

- If NYMC receives the completed enrollment package by the 20th day of the month, the enrollment will take effect on the first day of the next month. (For example: If your completed enrollment package is submitted by January 20, your enrollment would take place on February 1.)
- If the enrollment package is received after the 20th day of the month, the enrollment must take effect no later than the first day of the second month. (For example: If your completed enrollment package is submitted on January 22, your enrollment would take place on March 1.)

Withdrawal of Enrollment
If you want to stop the enrollment process after the initial visit, but before the start of your care, you can call us at 1-800-469-6292 (TTY: 711) to let us know that. You need to tell this to us in writing or over the phone, before 12:00 pm of the 20th day before your enrollment becomes effective. VillageCareMAX will work with New York State to process your request.

Denial of Enrollment
During the enrollment process, if it is found that you are not eligible for enrollment into VillageCareMAX, you will be informed in writing of the decision. Anytime your enrollment is going to be denied, the State must approve this decision.

VillageCareMAX will deny your enrollment under the following conditions:

- You do not meet the eligibility criteria listed above; You have Medicaid only (and not Medicare) are not eligible for nursing home level of care
- You do not need community-based long-term care services of the Plan for a continuous period of more than 120 days
- You are enrolled in one of the following: another managed care plan capitated by Medicaid, a Traumatic Brain Injury or Nursing Home Transition and Diversion Waiver program, a hospice, a State Office for People with Developmental Disabilities (OPWDD) program and you do not want to disenroll from any of these services
- You are a resident of psychiatric facility, alcohol/substance abuse long term residential treatment or assisted living programs
- You are expected to have Medicaid for less than 6 months, have Emergency Medicaid or are in Medicaid family planning expansion program
- You are in the Foster Family Care Demonstration
- You are a resident of an Assisted Living Program (ALP)
- You are under sixty-five (65) years of age in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage

Plan Member (ID) Card

You will receive your VillageCareMAX identification (ID) card within 10 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your ID card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at 1-800-469-6292 (TTY: 711).

SERVICES COVERED BY THE VILLAGECAREMAX MLTC PLAN

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services.

Upon enrollment, you will be assigned a Care Manager who is a Registered Nurse or Social Worker. The Care Manager will help to coordinate your care and will follow-up with you on a regular basis to check on your health care status. He/she will work with your physician, and other health care providers, to ensure that you are receiving all needed and ordered services. The Care Manager will also work with you to ensure that the care planning process is centered on your needs and preferences.

Your plan of care will be developed with a care team led by the Care Manager with your participation. The care team also includes your doctor, your caregiver(s), and other health care providers who will work together to develop a plan of care that meets your needs. The plan of care is a written description of your needs, services, and goals. It is based on an

assessment of your health care needs, the recommendation of your doctors, and your personal preferences. You will be given a copy of the plan of care for your records.

You can call our Member Services number at 1-800-469-6292 (TTY: 711) for after-hours care. During non-business hours, our answering service will be happy to take your message and will contact on-call staff to assist you. The person on-call will contact you as soon as possible. Note: if you have an emergency, please call 911.

Additional Covered Services
Because you have Medicaid and qualify for MLTC, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in VillageCareMAX network. If you cannot find a provider in our plan, VillageCareMAX will cover services you get from providers who are <u>not</u> part of the plan's network in these cases:

1. If you need medical care that Medicaid requires our plan to cover and the providers in our network cannot provide this care. You must get prior authorization from VillageCareMAX before getting care from the out-of-network provider.
2. If you are a new member and you are receiving long-term care services from fee for service Medicaid, like personal care, adult day health care, care in the nursing home and others. We must continue to cover these services from the out-of-network provider for at least 90 days after you join the plan.

The section below explains the Medicaid-covered benefits and coverage rules.

Service	Coverage Rules
Adult Day Health Care Provides care and services in a residential health care facility or approved extension site. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental pharmaceutical, and other ancillary services, as well as leisure time activities that are a planned program of diverse and meaningful activities. Adult Day Health Care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are not homebound. To be eligible, you must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services.	You must get Adult Day Health Care from the VillageCareMAX Provider Network, and get authorization from the Plan. Your doctor will need to provide signed written orders to the Adult Day Health Care provider. VillageCareMAX will assist your provider in obtaining doctor's orders, if needed.
Audiology/Hearing Aids Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting, and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings, and replacement parts.	You must get audiology/hearing aids from the VillageCareMAX Provider Network. Prior authorization may be required for certain services.

Service	Coverage Rules
Consumer Directed Personal Assistance (CDPAS) This is a self-directed program where a member or a person acting on a member's behalf, known as a designated representative, directs and manages the member's personal care services, home health aide services or skilled nursing tasks. Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping. This is provided by an aide chosen and directed by the member or a designated representative.	You must coordinate your consumer directed personal assistance services with a Fiscal Intermediary that works with VillageCareMAX. Prior authorization is required from VillageCareMAX.
Dental Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.	You must get dental services from the VillageCareMAX dental Provider Network. Prior authorization is required for certain services.
Durable Medical Equipment (DME) Durable medical equipment is made up of devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition. Durable medical equipment covered by Medicaid includes items such as tub stools, grab bars, medical/surgical supplies, and enteral formula that are not otherwise covered by Medicare.	You must get items from the VillageCareMAX Provider Network and get prior authorization from the plan for certain items. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Home-Delivered Meals and/or Meals in a Group Setting such as a day care Services include meals that are delivered at home or in a group setting for individuals who are unable to prepare meals or unable to get assistance with meal preparation.	You must get home delivered or congregate meals from the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.
Home Health Care Services Not Covered by Medicare (including nursing, home health aide, occupational, physical and speech therapies) Medicaid-covered home health services include the provision of skilled services not covered by Medicare. VillageCareMAX Medicare Total Advantage coordinates the provision of home care services including care from nurses, social workers, physical therapists, occupational therapists and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health.	You must get home health care services from the VillageCareMAX Provider Network. Services are based on a plan of care that your physician approves, and all services are provided in your home. Prior authorization is required from VillageCareMAX.
Medical Social Services These services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of your needs in your home when such services are performed by a qualified social worker. Medical social services will assist you with concerns related to your illness, finances, housing, or environment.	You must get Medical Social Services from the VillageCareMAX Provider Network. Prior authorization is required from VillageCareMAX.

Service	Coverage Rules
Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and device and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, non-reusable, disposable, and administered for a specific purpose.	These items may also be covered by Medicare. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders.
Non-emergency Transportation Non-Emergency Transportation is transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the member's condition to obtain necessary medical care and services reimbursed under the Medicaid or the Medicare programs.	You must get non-emergency transportation from the VillageCareMAX Provider Network, and call two days in advance to schedule, if possible.
Nursing Home Care not covered by Medicare (***provided you are eligible for institutional Medicaid***) Medicaid-covered care provided in a Skilled Nursing Facility.	You must get Medicaid covered nursing home care from the VillageCareMAX Provider Network provider, and get authorization from the Plan. Your doctor will need to provide signed written orders to the nursing home. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Nutrition Services/Counseling Services include the assessment of nutritional needs for your physical and medical needs and environmental conditions. These include the provision of nutrition education and counseling to meet your therapeutic needs and development of a nutritional treatment plan.	You must get Nutritional Services/Counseling from the VillageCareMAX Provider Network, and get authorization from the Plan.
Outpatient Rehabilitation ***Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home*** Physical therapy is rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level. Occupational therapy is rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level. Speech-language therapy is rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.	VillageCareMAX covers medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional. Prior authorization is required from VillageCareMAX. Your doctor will need to provide signed written orders to the Rehabilitation Therapist. VillageCareMAX will assist your provider in obtaining doctor's orders, if needed.

Service	Coverage Rules
Optometry/Eyeglasses Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses, and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.	You must get optometry services and eyeglasses from the VillageCareMAX Provider Network. Prior authorization may be required for certain services.
Personal Care (such as assistance with bathing, eating, dressing, toileting and walking) Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks.	You must get personal care from the VillageCareMAX Provider Network, and get authorization from the Plan. Your doctor will need to provide signed written orders. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Personal Emergency Response Systems (PERS) PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	You must get PERS from the VillageCareMAX Provider Network, and get authorization from the Plan.
Podiatry Podiatry means services by a podiatrist, which must include routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.	You can get podiatry services from the VillageCareMAX Provider Network. Prior authorization is not required.
Private Duty Nursing Private Duty Nursing are medically necessary services provided at enrollee's permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs).	You must get private duty nursing services from the VillageCareMAX Provider Network and requires a doctor's order. Prior authorization is required from VillageCareMAX.
Prosthetics, Orthotics and Orthopedic Footwear Prosthetic appliances and devices are appliances and devices that replace any missing part of the body. Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. Orthopedic footwear includes shoes, shoe modifications or shoe additions that are used to correct, accommodate or prevent a	You must get items from the VillageCareMAX Provider Network, and get prior authorization from the plan. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining

Service	Coverage Rules
physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot. Orthopedic footwear also is used to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.	doctor's orders if needed.
Respiratory Therapy The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, aerosol, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.	You must get respiratory therapy from the VillageCareMAX Provider Network, and get authorization from the Plan. Your doctor will need to provide signed written orders to the therapist providing care. VillageCareMAX will assist your provider in obtaining doctor's orders, if needed.
Social and Environmental Supports (such as chore services, home modifications or respite) Social and environmental supports are services and items that maintain the medical needs of the member and include the following: home maintenance tasks, homemaker/chore services, housing improvement and respite care.	You must get social and Environmental supports from the VillageCareMAX Provider Network, and get authorization from the Plan.
Social Day Care Social day care is a structured program that provides functionally impaired individuals with socialization, supervision, monitoring and nutrition in a protective setting during any part of the day. Additional services may include personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.	You must get Social Day Care from the VillageCareMAX Provider Network, and get authorization from the Plan.
Telehealth Telehealth is the use of technologies to deliver or support clinical health care for covered services from a distance to reduce the need for in-office visits. The services include live video between a member and a provider; transmission of recorded health history through a secure electronic communications system; and use of mobile devices to provide supportive services.	Telehealth can be received to support covered services only. You must get authorization from the Plan, as required.
Veteran's Home Services If you are a veteran, spouse of a veteran, or Gold Star parent in need of long-term nursing home services, you may access Veteran's Home Services.	If VillageCareMAX does not have an accessible in-network veteran's home, the plan will authorize out-of-network services until member is transferred to another plan with an in-network veteran's home. You must get authorization from the Plan.

Limitations
Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:

1. tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; ***and***
2. individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

Nursing Home Care is covered for individuals who are considered a permanent placement for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from VillageCareMAX.

Getting Care outside the Service Area
You must inform your care manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your care manager should be contacted to assist you in arranging services.

Emergency Service
Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify VillageCareMAX within 24 hours of the emergency. You may be in need of long term care services that can only be provided through VillageCareMAX.

If you are hospitalized, a family member or other caregiver should contact VillageCareMAX within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact VillageCareMAX so that we may work with them to plan your care upon discharge from the hospital.

TRANSITIONAL CARE PROCEDURES

New members in VillageCareMAX may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to VillageCareMAX quality assurance and other policies, and provides medical information about the care to your plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

MONEY FOLLOWS THE PERSON (MFP)/OPEN DOORS

This section will explain the services and supports that are available through **Money Follows the Person (MFP)/Open Doors**. MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP/Open Doors if you:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in their community

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Giving you information about services and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you need at home

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that VillageCareMAX does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-800-469-6292 (TTY: 711) if you have a question about whether a benefit is covered by VillageCareMAX or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy
Most prescription and non-prescription drugs, as well as compounded prescriptions are covered by regular Medicaid or Medicare Part D if you have Medicare.

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Intellectual and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services including:

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Family Planning
  Certain medically necessary ovulation enhancing drugs, when criteria are met.

SERVICES NOT COVERED BY VillageCareMAX OR MEDICAID

You must pay for services that are not covered by VillageCareMAX or by Medicaid if your provider tells Examples of services not covered by VillageCareMAX or Medicaid you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by VillageCareMAX or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless VillageCareMAX sends you to that provider)

If you have any questions, call Member Services at 1-800-469-6292 (TTY: 711).

SERVICE AUTHORIZATIONS, ACTIONS AND ACTION APPEALS

When you ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request, you must:

You, your authorized representative or your provider may call our toll-free Member Services number at 1-800-469-6292 (TTY: 711) or send your request in writing to VillageCareMAX 112 Charles St, New York, NY 10014.

We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period.**

Prior Authorization
Some covered services require **prior authorization** (approval in advance) from VillageCareMAX Utilization Management Department or contracted vendor before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- **Adult Day Health Care**
- **Audiology/Hearing Aids***
- **Consumer Directed Personal Assistance (CDPAS)**
- **Dental***
- **Durable Medical Equipment (DME)***
- **Home Delivered Meals and/or meals in a group setting such as a day care**
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies
- **Medical Social Services**
- **Medical Supplies**
- **Non-Emergency Transportation**
- **Nursing Home Care not covered by Medicare** ***(provided you are eligible for institutional Medicaid)***
- **Nutrition**
- **Optometry/Eyeglasses***
- **Outpatient Rehabilitation –** ***Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) in a setting outside of the home***
- **Personal Care**
- **Personal Emergency Response System (PERS)**
- **Private Duty Nursing**

- **Prosthetics, Orthotics and Orthopedic Footwear**
- **Respiratory Therapy**
- **Social and Environmental Supports**
- **Social Day Care**
- **Telehealth***
- **Veteran's Home Services**

An asterisk (*) means that prior authorization is required for certain services. Call the plan for more information.

Before you can get these services, you or your provider must submit the request to VillageCareMAX for prior authorization. This can be done by calling VillageCareMAX Member Services or sending your request in writing. The Utilization Management team will review your request, which includes working with providers to get all necessary medical documentation. A decision will be made as early as your condition requires, but no later than the required timeframes. See the benefit chart on pages 5-9 for more information on description of services and coverage rules.

Concurrent Review
You can also ask VillageCareMAX Utilization Management Department or contracted vendor to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review
Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

***What happens after we get your service authorization request*?**
The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or ***fast track*** process. You or your doctor can ask for a *fast track* review if it is believed that a delay will cause serious harm to your health. If your request for a *fast track* review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Timeframes for prior authorization requests

- **Standard review**: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

- **Fast track review**: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- **Standard review**: We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.

- **Fast track review**: We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a *fast track* review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-469-6292 (TTY: 711) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

If our answer is YES to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is NO to part or all of what you asked for, we will send you a written notice that explains why we said no. See ***How do I File an Appeal of an Action?*** which explains how to make an appeal if you do not agree with our decision.

What is an Action?

When VillageCareMAX denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations

within the required timeframes, those are considered plan “actions. An action is subject to appeal. (See *How do I File an Appeal of an Action?* below for more information.)

Timing of Notice of Action
If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action
Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State’s external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; ***and***
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you must file an appeal before asking for a Fair Hearing; ***and***
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?
If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 day of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?
We can be reached by calling 1-800-469-6292 (TTY: 711), or writing to 112 Charles St, New York, NY 10014. The person who receives your appeal will record it, and appropriate staff will

oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process
If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see "***How do I File an Appeal of an Action?"*** above.

Although you may request a continuation of services, if the plan appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will It Take the Plan to Decide My Appeal of an Action?
Unless your appeal is fast tracked, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request a "*fast track*" appeal. (See "**Fast Track Appeal Process"** section below.)

Fast Track Appeal Process
We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a *fast tracked* review of your appeal. of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for a *fast track* appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to

deny your request for a *fast track* appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?
If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: **You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.** If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings
If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under ***"How Long Will It Take the Plan to Decide My Appeal of an Action?"*** *above*, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.
If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

Your benefits will continue until you withdraw the Fair Hearing or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance (OTDA):

- Online Request Form: Request Hearing | Fair Hearings | OTDA (ny.gov)
- Mail a Printable Request Form:
  NYS Office of Temporary and Disability Assistance Office
  of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023
- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:
  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155
- Request in Person:
  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

  Albany
  40 North Pearl Street, 15th Floor
  Albany, New York 12243

For more information on how to request a Fair Hearing, please visit: http://otda.ny.gov/hearings/request/

State External Appeals
If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast track external appeal. The external appeal reviewer will decide a fast track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

COMPLAINTS AND COMPLAINT APPEALS

VillageCareMAX will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by VillageCareMAX staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint, please call: 1-800-469-6292 (TTY: 711) or write to: 112 Charles St, New York, NY 10014. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you, didn't show up, or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address and telephone number of the individual

we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial compliant decision.

For standard complaint appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the *fast track* complaint appeal process. For *fast track* complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and *fast track* complaint appeals, we will provide you with written notice of our decision of your complaint appeal. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

Participant Ombudsman
The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like VillageCareMAX. This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

- Phone: 1-844-614-8800 (TTY Relay Service: 711)
- Web: www.icannys.org | Email: ican@cssny.org

DISENROLLMENT FROM VillageCareMAX MLTC PLAN

You will not be disenrolled from the MLTC Plan based on any of the following reasons:

- high utilization of covered medical services
- an existing condition or a change in your health
- diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs unless the behavior results in your becoming ineligible for MLTC.

Voluntary Disenrollment
You can ask to leave the VillageCareMAX at any time for any reason.

To request disenrollment, call 1-800-469-6292 (TTY: 711) or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTSS.

Transfers
You can try our plan for 90 days. You may leave VillageCareMAX and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in VillageCareMAX for nine more months, unless you have good reason (good cause.)

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving VillageCareMAX is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause.

To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. VillageCareMAX will provide the care you need until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in VillageCareMAX.

Involuntary Disenrollment
An involuntary disenrollment is a disenrollment initiated by VillageCareMAX. If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of involuntary disenrollment reasons.

You Will Have to Leave VillageCareMAX if you are:

- No longer are Medicaid eligible.
- Permanently move out of VillageCareMAX service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- Hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- Assessed as no longer having a functional or clinical need for (CBLTSS) on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.

- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated.
- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We Can Ask You to Leave VillageCareMAX if you:

- or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the plan's ability to furnish services
- fail to pay or make arrangements to pay the amount money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, VillageCareMAX will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which you become ineligible for enrollment. If you continue to need CBLTSS you will be required to choose another plan or you will be automatically assigned (auto-assigned) to another plan.

CULTURAL AND LINGUISTIC COMPETENCY

VillageCareMAX honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

MEMBER RIGHTS AND RESPONSIBILITIES

VillageCareMAX will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

Member Rights

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.

- You have the Right to get information in a language you understand; you can get oral translation services free of charge.

- You have the Right to get information necessary to give informed consent before the start of treatment.

- You have the Right to be treated with respect and dignity.

- You have the Right to get a copy of your medical records and ask that the records be amended or corrected.

- You have the Right to take part in decisions about your health care, including the right to refuse treatment.

- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

- You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.

- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.

- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services.

- You have the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.

- You have the Right to appoint someone to speak for you about your care and treatment.

- You have the Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

- Receiving covered services through VillageCareMAX.
- Using VillageCareMAX network providers for covered services to the extent network providers are available.
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs.

- Sharing complete and accurate health information with your health care providers.
- Informing VillageCareMAX staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- Following the plan of care recommended by the VillageCareMAX staff (with your input).
- Cooperating with and being respectful with the VillageCareMAX staff and not discriminating against VillageCareMAX staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status.
- Notifying VillageCareMAX within two business days of receiving non-covered or non-pre-approved services.
- Notifying your VillageCareMAX health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing VillageCareMAX before permanently moving out of the service area, or of any lengthy absence from the service area.
- Your actions if you refuse treatment or do not follow the instructions of your caregiver.
- Meeting your financial obligations.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your care manager.

Information Available on Request

- Information regarding the structure and operation of VillageCareMAX.
- Specific clinical review criteria relating to a particular health condition and other information that VillageCareMAX considers when authorizing services.
- Policies and procedures on protected health information.
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.

- Provider credentialing policies.
- A recent copy of the VillageCareMAX certified financial statement; policies and procedures used by VillageCareMAX to determine eligibility of a provider.

NOTICE OF NON-DISCRIMINATION

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

VillageCareMAX provides the following:

- **Free aids and services to people with disabilitiesto 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 **VillageCareMAX** at 1-800-469-6292. For TTY/TDD services, call 711.

If you believe that **VillageCareMAX** 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 **VillageCareMAX** by:

Mail:	112 Charles Street, New York, NY 10014
Phone:	1-800-469-6292 (for TTY/TDD services 711)
Fax:	1-347-226-5180
In person:	112 Charles Street, New York, NY 10014
Email:	Complaints@villagecare.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 1-800-469-6292; TTY/TDD: 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-469-6292; TTY/TDD 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 1-800-469-6292; TTY/TDD 711.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-469-6292 رقم هاتف الصم والبكم 711	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-469-6292; TTY/TDD 711 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-469-6292 (телетайп: TTY/TDD 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-469-6292;TTY/TDD 711.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-469-6292; TTY/TDD 711.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-469-6292; TTY/TDD 711.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אײַך שפראך הילף סערוויסעס פרײַ פון אפצאל. רופט 1-800-469-6292 ; TTY/TDD 711.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-469-6292; TTY/TDD 711.	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-469-6292 /TTY/TDD 711.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-800-469-6292 TTY/TDD 711.	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-469-6292 TTY/TDD 711.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-469-6292 TTY/TDD 711.	Greek
خبردار: اگر آپ اردو بولتے ہیں تو آپکو زبان کی مدد کی خدمات مفت میں دستیاب ہیں کال کریں 1-800-469-6292; TTY/TDD 711.	Urdu

villagecaremax.org
1-800-469-6292 (TTY 711)
8 am to 8 pm, 7 days a week