2026

homefirst®
A product of Elderplan

Member Handbook

H3347_EPHF70315

Current as of 7/2/26

Important Contact Information

HomeFirst Member Services & Care Management Teams (Toll Free):
1-877-771-1119 (TTY: 711)
Monday – Friday, 8:30 a.m. – 5 p.m.
www.elderplan.org/about-us/homefirst-managed-long-term-care/

Elderplan/HomeFirst Community Offices:
Weekend appointments available by calling: 1-866-360-1934

Flushing Office (Queens)
36-59 Main Street, Flushing, NY 11354
Hours: Monday – Friday, 9 a.m. – 5 p.m.

Washington Heights Office (Manhattan)
564 West 181st Street, New York, NY 10033
Hours: Monday – Friday, 9 a.m. – 5 p.m.

Sunset Park Office (Brooklyn)
6405 7th Avenue, 2nd floor, Brooklyn NY 11220
Hours: Monday – Friday, 9 a.m. – 5 p.m.

Dental (DentaQuest)
1-844-231-8316 (TTY: 711)
Monday – Friday, 8 a.m. – 6 p.m.

Vision (Superior Vision)
1-844-353-2902 (TTY: 711)
Monday – Friday, 8 a.m. – 9 p.m.

Hearing (HearUSA)
1-800-442-8231
TTY/TDD: 1-888-300-3277
Monday – Friday, 8 a.m. – 8 p.m.

Medical Answering Services (MAS)
1-844-666 6270 – if you reside in the five boroughs of NYC, Nassau, Westchester or Putnam.

1-866-932-7740 – if you reside in Dutchess, Orange, Rockland, Sullivan, and Ulster Counties.
TTY: 711
Monday – Friday, 7 a.m. – 6 p.m.
www.medanswering.com/

Public Partnerships, LLC (PPL)
1-833-247-5346
TTY: 1-833-204-9042
Monday – Saturday, 8 a.m. – 8 p.m.
pplfirst.com/programs/new-york/ny-consumer-directed-personal-assistance-program-cdpap/

Tips To Help With Your Care
Always Remember To...

1. Tell your provider and other health care providers that you are a member of HomeFirst.
2. Call Member Services or your Care Management Team whenever you:
   - Require a service covered by HomeFirst or need help in obtaining a service.
   - Have questions if a service is covered under your long-term care benefits.
3. Notify HomeFirst within 24 hours if you are admitted to the hospital.
4. Bring your HomeFirst card, Medicare and Medicaid cards and other health insurance cards when you see your provider or other health care providers.

Table Of Contents

Welcome to HomeFirst Managed Long Term Care Plan

Welcome to HomeFirst, a product of Elderplan, and thank you for selecting us to serve your long-term care needs! HomeFirst is one of the oldest managed long-term care plans in New York. 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 HomeFirst covers since you are enrolled in the plan. The handbook also tells you how to request a service, file a complaint, or disenroll from HomeFirst. Please keep this handbook as a reference, it includes important information regarding HomeFirst and advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

If you would like more information, or have questions, please contact our Member Services team at 1-877-771-1119, Monday through Friday, 8:30am to 5:00pm. For TTY, call 711.

We encourage you and your family to take an active role in decisions about your long-term care needs. We want you to have an ongoing relationship with your Care Management team and your primary care provider as they work together to help you receive the home, community and facility-based health care services you need.

Thank you again for choosing HomeFirst.

About HomeFirst

HomeFirst, a product of Elderplan, is one of the oldest managed long-term care (MLTC) plans in New York. HomeFirst continues a tradition of compassion, dignity and respect that dates back to 1907 when the Four Brooklyn Ladies, with the help of charitable support, provided members of the community with quality health care and a safe, comfortable place to live in their time of greatest need. HomeFirst, a not-for-profit MLTC plan, brings people and resources together to better plan and deliver accessible, high quality health care services for you.

As a key part of that effort, HomeFirst has developed a respected network of area providers that are able to deliver the services you may require.

These providers have all been selected and credentialed by us to ensure you receive quality care.

We encourage our members to take an active role in their own health care and we offer many choices in services and locations to assist in that effort. It's all part of our commitment to you. Our goal is to help you live independently, in your own home, for as long as possible.

Enrollment in HomeFirst is entirely voluntary. When you enroll in HomeFirst you are required to use providers in the HomeFirst network and obtain authorization from your Care Management Team for services covered by HomeFirst.

What Is Managed Long-Term Care and How Does It Work?

Managed long-term care plans provide, arrange and coordinate members' long-term care services on a capitated basis. At HomeFirst, we offer you a wide selection of covered services through our network providers at no cost to you (see **Services Covered by HomeFirst** section on page 18) and can coordinate other services including those covered by Medicare or regular Medicaid (see page 38).

As a Member of HomeFirst, you will benefit from:

- Coordination of all your health care services with your physician(s) and other health care providers.
- A Care Management Team comprised of a registered nurse assessor, care manager and care representative with expertise in caring for individuals with chronic medical needs.
- Your Care Management Team will collaborate with your physician and other health care professionals to ensure you receive the services you need.
- A plan of care that you, your Care Management Team, and your Provider(s) design specifically for you.
- Extensive choices in services, including preventive, rehabilitative and community-based services.
- An on-call nurse, who is available 24 hours a day, 7 days a week for information, emergency consultation services and response in the community, if necessary.

Confidentiality

We protect the privacy of your Personal Health Information. Federal and state laws protect the privacy of your medical records and personal health information. HomeFirst takes your privacy seriously. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called "Notice of Privacy Practices," that tells about these rights and explains how we protect the privacy of your health information.

How We Protect the Privacy of Your Health Information

- We make sure that unauthorized persons don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first.
- These exceptions are allowed or required by law. For example, we are required to release health information to government agencies that are checking on quality of care.

You can see the information in your records and know how it has been shared with others. You have the right to look at your medical records held at the plan, and to get a copy of your records.

We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, or for a copy of our plan's "Notice of Privacy Practices," please call Member Services at 1-877-771-1119 (TTY: 711).

Help From Member Services

You can call your HomeFirst Member Services 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**:
Call **1-877-771-1119 (TTY: 711)**,
Monday through Friday 8:30am to 5:00pm

If you need help after work hours, on a weekend or during a holiday, a member of our staff will assist you. An on-call nurse will answer your questions regarding your medical condition and help you decide on a course of action. They may also refer you to a hospital, contact your physician or follow up if there is a problem with a provider or service. You can contact the same Member Services number at 1-877-771-1119 (TTY: 711).

Our Member Services Representatives are available to help you in any way regarding your membership. If you have any questions or concerns about benefits, services or procedures, please let us know. We welcome any ideas or suggestions you might have regarding HomeFirst. Your comments help us improve our services to you.

Interpreter and Translation Services

HomeFirst has employees who speak many languages, including access to interpreter services at no charge to you. HomeFirst shall advise you that you are entitled to receive language interpretation services upon request at no charge to you. We also have written information in the most prevalent languages of our members.

Currently written materials are available in English, Russian, Chinese, Bengali, Haitian Creole, Spanish, Korean, Hindi, Urdu, Punjabi, and Arabic. If translation is required, please feel free to call Member Services at 1-877-771-1119 (TTY: 711) and request to speak with an interpreter or to receive written materials in your language.

Services for Hearing Impaired Members

Hearing impaired members with TTY/ TDD ability who wish to speak with a Member Services Representative should first contact a relay operator at 711. They will then facilitate calls between TTY/TDD users and voice customers.

Services for Visually Impaired Members

HomeFirst also has materials like member handbooks in Braille, CDs, or audio tapes available upon request for those members who are visually impaired. Please contact Member Services to request a copy. Should you need the handbook or any other HomeFirst documents and forms read to you, HomeFirst will arrange an appointment for this service at your convenience.

Eligibility for Enrollment in HomeFirst

The HomeFirst managed long-term care (MLTC) plan is for people who have Medicaid. You are eligible to join the MLTC plan if you:

1) Are age 18 years and older;
2) Reside in the plan's service area which is the five boroughs of New York City (Manhattan, Brooklyn, Bronx, Queens, Staten Island), Nassau, Westchester, Dutchess, Putnam, Orange, Rockland, Sullivan, and Ulster counties;
3) Are eligible for full Medicaid as determined by Local Departments of Social Services (LDSS) or Human Resource Administration (HRA),
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) Need at least one Community Based Long-Term Care (CBLTSS) for more than 120 continuous days from the effective date of enrollment, and the following:
   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

7) Meet the Minimum Needs requirement from the effective date of enrollment:
   a. At least limited assistance with physical maneuvering with more than two activities of daily living (ADLs); or
   b. Individuals with a Dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one ADL

If you enrolled in the MLTC program as of August 2025, you will be granted MLTC Plan Legacy status and be assessed under previous criteria as long as you remain continuously enrolled. As a result, you will not be required to meet the Minimum Needs requirement at reassessment.

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

New York Independent Assessor Program – Initial Assessment Process

The New York State Department of Health will use the New York Independent Assessor Program (NYIAP) to support the assessment process for all long-term care plans. The NYIAP will manage the initial assessment process. NYIAP 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.

As part of the CHA, NYIAP will also assess if you meet one of the minimum needs requirements:

a. Needing at least limited assistance with physical maneuvering with more than two activities of daily living (ADLs); or
b. Individuals with a Dementia or Alzheimer's diagnosis and needing at least supervision with more than one ADL.

To qualify based on a diagnosis of Alzheimer's disease or dementia, you must provide a DOH-5821 Form signed by a physician and provide the completed form to NYIAP.

The NYIAP 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 NYIAP will complete a clinical appointment and PO a few days later.

HomeFirst 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 NYIAP 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 HomeFirst about whether the plan of care meets your needs.

Once NYIAP 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.

Enrollment

To support your enrollment process into our plan, a HomeFirst Enrollment Representative will assist you in scheduling an appointment with our Enrollment Nurse. You will be required to share any insurance cards with our Enrollment Nurse, including your Medicaid and Medicare cards, if eligible. This will allow our Enrollment Nurse to review your health care history and/or NYIAP assessment to determine what your care plan needs are. Based on this information, we will develop a personalized and detailed care plan that best supports your health care needs. We will also review this plan with you, gather your feedback, and answer any questions you may have.

If you are interested in enrolling in HomeFirst, you will be asked to sign a medical release. A signed medical release is needed for a HomeFirst nurse to follow up with your physician and other health providers to develop your personalized plan of care. Your plan of care will be developed with assistance from you, your informal supports and your physician/provider. HomeFirst will then be able to establish and coordinate the services included in your personalized plan of care. Social Day Care services can contribute to your personalized care plan, but cannot be the sole service that you will receive.

If you are choosing to enroll in HomeFirst from a Mainstream Medicaid Managed Care Plan and are a Medicaid-only Recipient, both you and your provider must complete the required NYIAP Assessment Request form before the NYIAP Assessment can be scheduled. In this form, both you and your primary care provider, nurse practitioner or physician

assistant must attest that you require at least one of the following services exclusive to managed long-term care plans: social day care, social and environmental supports and/or home delivered meals. Without this signed form, you will not be able to schedule a NYIAP Assessment or enroll in a managed long-term care plan like HomeFirst.

To conclude the enrollment application process, you will need to sign an Enrollment Agreement. A signed Release of Information is required to complete your application.

Enrollment will begin the first (1st) day of the month. All enrollments are subject to approval by the LDSS/ or New York Medicaid Choice. Applications for enrollments submitted to LDSS or New York Medicaid Choice by noon on the twentieth (20th) day of the month will be accepted for enrollment on the first (1st) of the following month if the application is complete and your Medicaid is active. If the twentieth (20th) day of the month falls on a holiday or weekend, the enrollment application will be submitted by noon of the prior workday.

Withdrawal of Enrollment

If you decide not to proceed with the application, this will be considered a withdrawal of the application. You may withdraw your application or enrollment agreement by noon on the twentieth (20th) day of the month prior to the effective date of enrollment by indicating your wishes to us verbally or in writing.

If you choose to withdraw your application, and are:

- **Dually eligible:** you must choose another managed long-term care plan in order to continue to receive long-term care services such as personal care. You are no longer able to return to Medicaid Fee-for- Service through HRA or LDSS.

- **Eligible for Medicaid only:** you must choose another managed long-term care plan, Medicaid managed care plan or waivered service in order to receive long-term care services. You are no longer able to return to Medicaid Fee-for-Service for long-term care through HRA or LDSS.

Denial of Enrollment

HomeFirst will tell you if you are determined to be ineligible based on age, geographic location of residence or Medicaid eligibility. If you do not agree with HomeFirst's decision, you may request to pursue an application. The information collected up to this time will then be forwarded to New York Medicaid Choice and they will make the final decision about your eligibility.

You will be denied enrollment if after the start of the application process it is determined you are not eligible for nursing home level of care if you are either 18–20 years old and dually eligible (Medicare and Medicaid), or if you are 18 years old or greater and only eligible for Medicaid.

- You will be denied enrollment if after the start of the application process it is determined that you do not require the community-based long-term care services offered by HomeFirst for more than one hundred twenty (120) continuous days from the date of enrollment.
- You will be denied enrollment if at the time of enrollment it is determined that you are not able to return to or remain in your home and community without jeopardy to your health and safety.

Before the recommendation for denial of enrollment is processed by the New York Medicaid Choice, you can withdraw your application by providing your wishes orally or in writing.

If HomeFirst or an entity designated by the Department of Health determines that you do not meet one or more of the eligibility requirements, then denial of enrollment will be recommended and you will be notified in writing. You will only be denied enrollment by HomeFirst if New York Medicaid Choice agrees with HomeFirst's determination that you are ineligible.

Coordinating Your Care

Upon enrollment, each member is assigned to a Care Management Team which includes a registered nurse assessor, care manager, and care coordinators. This team is responsible for the coordination of your ongoing care and providing a high-quality, person-centered service planning experience.

Person Centered Service Plan (PCSP)

The Person-Centered Service Plan (PCSP) must be developed with you and those individuals you select to participate in service planning and delivery, including service providers and your chosen informal supports. Our care managers will talk to you about your cultural preferences and range of services (such as scope, duration, amount, and frequency) to develop this plan. You are empowered to direct your own care plan. Services will not be planned or authorized until our care manager meets and collaborates with you. The completed PCSP must be signed by you, and a copy must be provided to you, and a signed copy must be retained by HomeFirst.

Together, your Care Management Team will work with you, your informal supports and your primary care provider to ensure you receive the appropriate level of services based on your current and unique psychosocial

and medical needs, functional level and support systems. Your Care Management Team will coordinate all of your health care needs for covered and non-covered services, and any other services provided by other providers, community resources and informal supports.

A Health Care Professional will assist you with applying for any entitlements and other benefits for which you are eligible, as well as in maintaining eligibility through the certification process of all entitlements. The Nurse Assessor, as a member of your Care Management Team, will make a home visit annually to complete a comprehensive assessment of your health and to identify any changes or needs you may have. Additional home visits may be scheduled as determined by your Care Management Team, upon your provider's request, or based on changes in your health conditions. We will work cooperatively with your physician/provider, who is notified of your plan of care, as well as other health care professionals to ensure you receive the services you need.

After the initial assessment and developing the plan with you, our Care Management Team will send the PCSP to you upon enrollment. Our care managers will also partner with you to review this plan whenever you need to be reassessed.

Role of Member Services

Member Services Representatives are available by telephone to assist you with any questions that you may have regarding HomeFirst, including benefits and services that are or are not covered. You can contact Member Services at 1-877-771-1119 (TTY: 711), Monday through Friday, 8:30 a.m. to 5:00 p.m. Member Services will work with your Care Management Team to schedule your appointments and order the supplies and services that you need. They will also work with your Care Management Team

and the service vendors to ensure that you receive the services you need or to resolve any problems you have with your services. Member Services Representatives can answer most questions you have regarding your plan of care. If necessary, they will ensure your Care Management Team contacts you to explain any medical questions you might have.

Choosing Your Primary Care Provider

With HomeFirst, you continue to use your own primary care provider. Your Care Management Team will work with your primary care provider to coordinate all your health care needs. If you need help finding a provider, we can help you locate a provider in the community that meets our quality standards.

Choosing Your Health Care Providers

We cannot restrict your ability to choose non-network service providers for your Medicare covered benefits. We do, however, believe that it is in your best interest to use our network providers. Since these network providers have a contractual obligation to HomeFirst, we have the ability to monitor their services and hold them accountable to our professional standards. If your Medicare benefits are exhausted and Medicaid becomes the primary payer for a covered service, you will need to switch to one of our network providers.

As a HomeFirst member, you may obtain a prior authorization to a health care provider outside the network in the event HomeFirst does not have a provider with appropriate training or experience to meet your needs. In the event that you require an out-of-network provider, please contact your Care Management Team to assist you to obtain a prior authorization. See **Service Authorizations, Actions and Action Appeals** section on page 47 for more information.

Referrals to Providers Outside of HomeFirst Provider Network

If the network does not have an appropriately trained or experienced provider for the specialty care you require, your Care Management Team will assist you in arranging care with the appropriate specialist (such as a specialty dentist) by working with your provider.

When using a provider outside of HomeFirst's network for covered services, you must get authorization before seeing the provider. Without first obtaining the required authorization, the provider will not be paid for their services.

Prior authorization from HomeFirst is not required if the services you need are covered by Medicaid Fee for Service, or if Medicare is the primary payer of a covered service. If you have questions regarding what services are covered under Medicare, please contact Member Services at 1-877-771-1119 (TTY: 711), Monday through Friday, 8:30 a.m. to 5:00 p.m.

Changing Your Provider

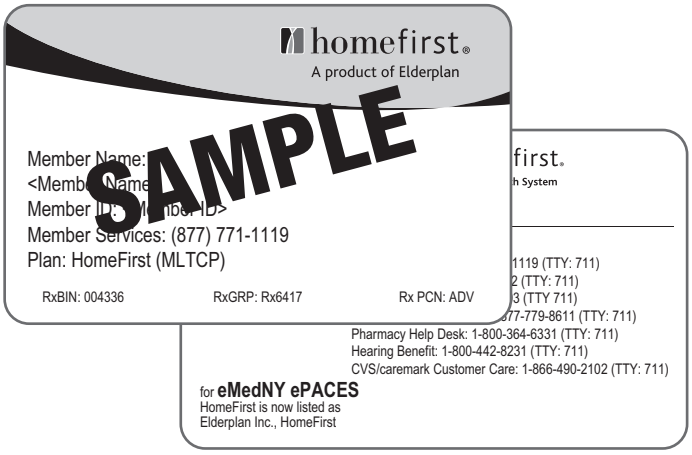
To change your provider, you should inform HomeFirst of your desire to make a change. To do so, simply call Member Services at 1-877-771-1119, Monday through Friday, 8:30 a.m. to 5:00 p.m., (TTY: 711). The change will become effective immediately.

HomeFirst Member ID Card

Upon enrollment, you will be assigned a Care Management Team and issued a HomeFirst member ID card. You will receive your ID card within 10 days of your effective enrollment period. Please verify that all information is correct on your card.

Your HomeFirst member ID Card identifies you as our member and should be carried along with your Medicaid, Medicare and all other health insurance cards, at all times. You will need your HomeFirst member ID card to access certain services that are authorized by HomeFirst.

HomeFirst Member ID Card



If your card becomes lost or is stolen, please contact Member Services at 1-877-771-1119 (TTY: 711).

Services Covered By HomeFirst

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 support you in arranging for transportation to those services. See the **Coordinating Your Care** section on page 14 for more information.

Additional Covered Services

HomeFirst offers a wide range of home, community and facility-based health care services and Long-Term Services & Supports (LTSS). Long-Term Services & Supports are health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals and administering medications.

Because you have Medicaid and qualify for MLTC, HomeFirst will arrange and pay for the 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 the HomeFirst network. See **Coordinating Your Care** section on page 14 on how to request services from a provider not in our network.

Covered Services Chart

Care Management	A process that assists the member to access necessary covered services as identified in the Person-Centered Service Plan (PCSP). Care Management services include referrals to in-network providers, assistance in or coordination of services for the member to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP, irrespective of whether the needed services are included in the benefits.

Nursing Home Care	Care provided to members by a licensed Facility. Please refer to the Nursing Home Care details on page 46 for more information.
Home Care **a.** Nursing **b.** Home Health Aide **c.** Physical Therapy (PT) **d.** Occupational Therapy (OT) **e.** Speech Language Pathology (SP) **f.** Medical Social Services	Includes preventive, therapeutic rehabilitative, health guidance and/or supportive care. Prior authorization is required.
Personal Care Services (PCS)	Provision of some or total assistance with such activities as personal hygiene, dressing and feeding and nutritional and/or environmental support function tasks by another person. Personal care must be medically necessary and provided by a qualified person in accordance with the plan of care. Prior authorization is required.

Consumer Directed Personal Assistant Services (CDPAS)	Consumer Directed Personal Assistance Services (CDPAS) is the provision of assistance with personal care services, home health aide services, and skilled nursing tasks by a consumer directed personal assistant. The member or member's designated representative is responsible for supervising and directing this personal assistant. To learn more about CDPAS, contact your Nurse Assessor or Care Manager. A CDPAS personal assistant can be a friend, family, or someone that the member chooses. However, a CDPAS personal aide cannot be someone who is legally responsible for the member, a spouse, or the back-up and safety person responsible for the member. The member and/ or designated representative is responsible for hiring, training, supervising and, if necessary, terminating the employment of the aide. A practitioner order and prior authorization is required.

Durable Medical Equipment (DME)	Devices and equipment, other than prosthetic, orthotics or orthopedic footwear, which have been ordered by a practitioner in the treatment of a specific medical condition. Includes medical equipment and hearing aid batteries. Prior authorization is required.
Medical/Surgical Supplies	Items for medical use other than drugs, prosthetics, orthotics, durable medical equipment or orthopedic footwear. Includes enteral nutritional formula coverage, which is limited to tube feeding and inborn metabolic diseases, and oral nutritional supplements. For members between the ages of 18 and 21, oral formulas remain covered when caloric and dietary nutrients cannot be absorbed or metabolized. Prior authorization is required.
Orthotics and Prosthetics	Includes orthotics, orthopedic footwear and prosthetics. Prior authorization is required.

Personal Emergency Response Systems (PERS)	PERS is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. Prior authorization is required.
Podiatry	Includes 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 a necessary and integral part of medical care, such as the diagnosis and treatment of diabetes, ulcers 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 a medical condition. Prior authorization is required.

Dental	Includes but is not limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, dental prosthetic and orthotic appliances to alleviate a severe health condition. Also includes coverage of crowns and root canals in certain circumstances so that you can keep more natural teeth. Replacement dentures and implants will only need a recommendation (not a referral) from the dentist to determine medical necessity. DentaQuest is HomeFirst's dental provider. Please contact DentaQuest at 1-844-231-8316 (TTY: 711), Monday through Friday, 8 a.m. to 6 p.m. Show your HomeFirst member ID card when you visit your dentist or whenever you access dental benefits. You will not receive a separate dental ID card. Prior authorization may be required.

Optometry/Eyeglasses	Includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. Eye exams are also covered to detect visual defects and eye disease. Exams which include refraction are limited to every two (2) years unless otherwise justified as medically necessary. Superior Vision is HomeFirst's vision provider. Contact Superior Vision at 1-844-353-2902 (TTY: 711), toll-free Monday through Friday, 8 a.m. to 9 p.m. Routine vision services do not require an authorization. Medically necessary services may require prior authorization.
Outpatient Rehabilitation Therapy: Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SP) or other Rehabilitative Therapies provided in a setting other than a home	Rehabilitation services provided by a licensed and registered therapist, for the purpose of maximum reduction of physical or mental disability and restoration of the member to their best functional level, provided in a setting other than a home. HomeFirst will cover medically necessary PT, OT and SP visits that are ordered by a doctor or other licensed professional. Prior authorization is required.

Nutrition	The assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. Prior authorization is required.
Private Duty Nursing	Medically necessary services provided to members at their permanent or temporary place of residence by properly licensed registered professional or licensed practical nurses (RNs or LPNs) in accordance with physician orders. Private Duty Nursing Services may be continuous and go beyond the scope of care available from a Certified Home Health Care Agency (CHHA). Prior authorization is required.
Home Delivered or Congregate Meals	Meals provided to members who are unable to plan, shop for or prepare such meals due to illness, disability or advanced age. Meals may be provided at home or in congregate settings (e.g., senior centers). Prior authorization is required.

Adult Day Health Care	Care and services provided in a residential health care facility or approved extension site, including the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities, dental, pharmaceutical and other ancillary services. Prior authorization is required.
Social Day Care Services	Structured, comprehensive program which provides functionally impaired individuals with socialization, supervision and monitoring, personal care, and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Prior authorization is required.
Social and Environmental Supports	Services and items that support your medical needs that include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement and respite care. Prior authorization is required.

Respiratory Therapy	Respiratory therapy is used to treat chronic and acute respiratory illnesses. These services must be provided by a qualified respiratory therapist. Treatment would include the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures, including the application of medical gases, humidity, and aerosols, 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. Your physician would provide a medical order to treat your specified conditions. Prior authorization is required.
Audiology/Hearing Aids	Includes audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription, fitting, dispensation and repair. Prior authorization is required.

Telehealth	Telehealth-delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a member. Telehealth does not include delivery of health care services by means of audio only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. Prior authorization is not required.
Veterans Home Benefits	Each veteran, spouse of a veteran, or Gold Star Parent member in need of long-term placement is eligible for Veterans Home placement and will be notified by HomeFirst of availability in the network. If HomeFirst does not operate in an area with an accessible Veterans Home, or does not have one in its network, you will be directed to the enrollment broker. Prior authorization is required.

Consumer Directed Personal Assistance Services (CDPAS)

Public Partnerships LLC (PPL) is the only statewide fiscal intermediary in New York. PPL is the only entity that can provide CDPAS services to you. If you have a family member or friend that wants to be your personal aide, then they are required to register with PPL.

PPL also has a network of Consumer Directed Personal Assistance Program (CDPAP) facilitators that can assist you or your personal aide. They are community-based organizations located throughout New York, and have locations for you to visit in-person.
Go to: **pplfirst.com/cdpap-facilitators/** for more information.

You can also contact PPL by phone if that is your preference. You can call PPL if you speak the below languages:

Language	Telephone Number	Hours of Operation
English (or for other languages)	1-833-247-5346	Monday to Saturday, 8:00 a.m. to 8:00 p.m.
Spanish	1-833-281-0927	Monday to Saturday, 8:00 a.m. to 8:00 p.m.
Chinese	1-833-279-3467	Monday to Friday, 8:00 a.m. to 6:00 p.m.
Arabic	1-833-279-4829	Monday to Friday, 8:00 a.m. to 6:00 p.m.
Haitian Creole	1-833-279-3513	Monday to Friday, 8:00 a.m. to 6:00 p.m.
Urdu	1-833-281-3277	Monday to Friday, 8:00 a.m. to 6:00 p.m.

For TTY, dial 1-833-204-9042

PPL also has dedicated translation services to more than 300 languages.
Go to: **pplfirst.com/programs/new-york/ny-consumer-directed-personal-assistance-program-cdpap/** for more information.

Social Care Network

You can receive screening and referral to existing local, state and federal services through regional Social Care Networks (SCNs). If you are eligible, these local groups can connect you to services in your community that help with housing, transportation, education, employment, and care management at no cost to you.

- After screening through this SCN, you and any interested member(s) in your household can meet with a Social Care Navigator who can confirm eligibility for services that can help with individual health and well-being. They may ask you or members in your household for supporting documentation to determine where extra support may be needed.
- If you or any member(s) in your household qualify for services, the Social Care Navigator can work with you to get the support needed. You may qualify for more than one service, depending on individual eligibility. These services include:
  - Housing and utilities support:
    - Installing home modifications like ramps, handrails, grab bars, pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, and non-skid surfaces to make your home accessible and safe.
    - Mold, pest remediation, and asthma remediation services.
    - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
    - Providing small refrigeration units needed for medical treatment.
    - Helping you find and apply for safe and stable housing in the community which may include assistance with rent and utilities.

NOTE: Some housing services may be covered by your plan. Therefore, some housing services will require coordination between the Social Care Navigator and your health plan's care manager.

– Transportation services:
  - Helping you with access to public or private transportation to places approved by the SCN such as going to a job interview, parenting classes, housing court to prevent eviction, local farmers' markets, and city or state department offices to obtain important documents.

– Care management services:
  - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
  - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

Getting in Contact with an SCN in your area:

1. You may call HomeFirst at 1-877-771-1119 (TTY: 711) and we will connect you to a SCN in your area.
2. You may call the SCN within your county and request a screening or more information. See the SCN contact information in the chart below.
3. You may also visit their website to begin a self-screening.

Once connected with the SCN, a Social Care Navigator will confirm your eligibility by asking questions, requesting supporting documentation (if necessary), tell you more about eligible services, and help you get connected to them.

SCN	Counties	Phone number
Health Equity Alliance of Long Island	Nassau	1-516-505-4434
	healiny.org/	
Hudson Valley Care Coalition, Inc	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	1-914-215-5292
	hudsonvalleycare.org/services/hudson-valleys-social-care-network/	
Public Health Solutions	Manhattan, Queens, Brooklyn	1-888-755-5045
	wholeyou.nyc/	
Staten Island Performing Provider System	Richmond Brooklyn: 11209, 11219, 11220, 11228 Queens: 11355, 11368, 11373, 11377	1-917-830-1140
	statenislandpps.org/social-care-network/	
Somos Healthcare Providers, Inc.	Bronx	1-833-SOMOSNY (1-833-766-6769)
	somoscommunitycare.org/social-care-network/	

The SCNs will be providing these services are available until 3/31/27 or later, based on DOH guidance.

Additional Covered Services Details

All covered services are provided by or contracted through HomeFirst. Check the current provider network in your HomeFirst enrollment materials, visit the HomeFirst website at **elderplan.org/member- benefits/homefirst-benefits/homefirst-provider-network/**, or call Member Services for a list of network providers if you cannot find one. Your provider must get authorization from HomeFirst for certain covered services. HomeFirst will make every effort to authorize services as quickly as your condition requires.

Upon enrollment, you will receive a HomeFirst member ID card. It is important to carry it at all times. As a HomeFirst member, you are not liable to pay for covered services from network providers when the prior authorization procedure is followed. In the event that you receive a bill directly from a network provider, you must notify HomeFirst. We will contact the network provider to correct their error.

HomeFirst members can self-refer for the following services at Article 28 Clinics.

- Vision Services: optometry services affiliated with College of Optometry of the State University of New York
- Dental Services: operated by academic medical centers

HomeFirst may cover oral supplements if the member meets eligibility criteria and receives a prior authorization from the plan. Coverage of enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions including but not limited to:

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 HomeFirst.

Getting Care Outside the Service Area

You must inform your care manager when you travel outside your coverage area, and preferably before you travel. Should you find yourself in need of services outside your coverage area, our Member Services team and care managers should be contacted. We will help you arrange for medically necessary care while you are away. You can contact Member Services at 1-877-771-1119 (TTY: 711), Monday through Friday, 8:30 a.m. to 5:00 p.m.

If you are planning to leave the service area for more than (30) thirty consecutive days, it will be difficult for HomeFirst to properly monitor your health needs. When this happens HomeFirst must initiate disenrollment within five (5) work days after the thirty (30) days have passed. In this case, you should call Member Services or your Care Management Team to discuss your options.

Out of Area Emergency Care

If an emergency situation occurs while you are out of the area, you should seek care immediately. You, a family member or friend should contact HomeFirst within 2 hours if possible. We need to have this information to make any appropriate plan of care changes that may be necessary.

Out of Area Urgent Care

An urgent care need is an illness or medical problem that needs attention by your physician or other health care provider before your next routine office visit. If you require urgent care when you are out of the service area, HomeFirst will accept the medical necessity decision made by the attending physician or other health care professional. HomeFirst will pay for any services that are ordered by the provider that are covered services through HomeFirst.

Emergency Service

Emergency Service means a sudden onset of a condition that poses a serious threat to your health. You are NOT required to obtain HomeFirst's prior authorization to get emergency care.

For medical emergencies:

- Call 911 or go to the nearest Emergency Room.
- You do not need to inform HomeFirst before seeking emergency medical treatment.
- Call or text 988 if you need immediate mental health support

As noted above, prior authorization is not needed for emergency service. However, you should notify HomeFirst within 24 hours of the emergency. You may be in need of long term care services that can only be provided through HomeFirst. Your Care Management Team will work with you and your providers to coordinate the care that you need.

If you are hospitalized, a family member or other caregiver should contact HomeFirst 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 HomeFirst so that we may work with them to plan your care upon discharge from the hospital.

Transitional Care Procedures

New members in HomeFirst may continue an ongoing course of treatment related to a life-threatening disease or condition or a degenerative or disability disease or condition 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 HomeFirst's quality assurance and other policies, and provides medical information about the care to your plan. Transitional care only applies to services and benefits covered by HomeFirst.

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.

If you feel you have a condition that meets the criteria for transitional care services, please notify your Care Management Team.

If you are being disenrolled from another MLTC Plan into HomeFirst due to an approved service area reduction, closure, acquisition, merger, or other approved arrangement, HomeFirst must continue to provide services under your current existing Person Centered Service Plan for a continuous period of one hundred twenty (120) days after enrollment or until HomeFirst has conducted an assessment and you have agreed to the new Person Centered Service 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 **health.ny.gov/mfp** or **ilny.org**.

Medicaid Services Not Covered by Our Plan

There are some Medicaid services that HomeFirst 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 1-877-771-1119 (TTY: 711) if you have a question about whether a benefit is covered by HomeFirst 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.

Other services not covered by HomeFirst, but covered by Medicare or regular Medicaid are:

Inpatient Hospital Services	Inpatient hospital services include care, treatment and nursing services that require an admission to the hospital.
Outpatient Hospital Services	Are services which are provided by a hospital providing diagnosis, treatment or prevention services for patients not requiring an overnight hospital stay.
Laboratory Services	Include medically necessary tests and procedures ordered by a qualified medical professional.
Physician Services, including services provided in an Office Setting, a Clinic, a Facility or in the Home	Physician services include the services of physician assistants and social workers provided in the office, home and facilities.
Radiology and Radioisotope Services	Diagnostic radiology, ultrasound, nuclear medicine, radiation oncology and magnetic resonance imaging (MRI) services performed upon the order of a qualified practitioner.
Non-Emergency Medical Transportation	Scheduled rides to and from appointments for routine or urgent medical, dental, and other health services that are not life-threatening emergencies.
Emergency Transportation	Emergency or Ambulance Transportation to a Hospital

Rural Health Clinic Services	Programs servicing Medicare and Medicaid beneficiaries in rural areas to increase the utilization of non physician practitioners (e.g., Nurse Practitioners and Physician Assistants).
Chronic Renal Dialysis	Services and treatment of chronic renal disease.
Mental Health Services	Include both inpatient and outpatient care and treatment of mental health patient services including medication and psychiatric hospital admissions.
Alcohol and Substance Abuse Services	Treatment and prevention of alcohol and drug addictions.
Office for People with Developmental Disabilities (OPWDD)	Long-term therapy primarily serving persons with developmental disabilities: day treatment services and home and community based program services for the developmentally disabled.
Hospice	Hospice programs provide patients and families with supportive and end of life care to meet the special needs experienced during the final stages of illness.

Although these services are not part of HomeFirst's benefit package, your Care Management Team will help arrange and coordinate them as needed. If you are currently enrolled in another health plan that covers all or part of these services, you may wish to keep that coverage in effect to continue receiving these benefits.

Services not covered by HomeFirst or Medicaid

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

If you have any questions, call Member Services at 1-877-771-1119 (TTY: 711).

Coordination of Covered and Non-Covered Services

Enrolling in HomeFirst does not affect your Medicare Benefits. You will continue to be covered by Medicare for your provider visits, hospitalizations, lab tests, ambulance and other Medicare benefits. You do not need HomeFirst's authorization to receive Medicare services.

However, HomeFirst can:

- Provide you with a list of qualified providers (if you don't have one already).
- Schedule provider appointments.
- Assist with your discharge arrangements if you are hospitalized.
- Arrange Medicare covered home care services.

If you are receiving any service covered by HomeFirst (see page 18) and it is determined that it is also covered under Medicare, your provider will bill Medicare as your primary insurance. If Medicare does not cover the entire cost of the covered service, then HomeFirst will be billed for any deductibles or coinsurance.

Any service you receive that is a non-covered HomeFirst service (see page 38) will be billed to Medicare as your primary insurance. If Medicare does not cover the entire cost of that service, the remaining balance will be billed to Medicaid Fee for Service. Your HomeFirst member ID Card identifies you as a HomeFirst member and should be carried, along with your Medicaid, Medicare and all other health insurance cards, at all times.

You will need your HomeFirst member ID card to access certain services that are authorized by HomeFirst.

If a covered service you currently receive is a Medicare covered service, you can continue using the provider of your choice. HomeFirst recommends that you use a provider in our Network so that you will not have to change providers if Medicare coverage limits are met and HomeFirst becomes responsible for primary payment for the care.

Medicaid will pay for services not covered by HomeFirst. You can access services such as dialysis, mental health and substance use disorder counseling, or alcohol detoxification through Medicaid directly. These services are not covered by HomeFirst. You do not need HomeFirst to authorize these types of services. Your Care Management Team can make it easier for you by helping you obtain and coordinate Medicaid-covered services with HomeFirst services.

How to Obtain Covered Services

Plan of Care Development and Monitoring

When you enroll, you, your provider and your Care Management Team will work together to develop a plan of care that meets your needs. Your plan of care will include all of the services you need to maintain and improve your health status. The plan of care includes both services covered

by HomeFirst and those services covered by Medicaid and Medicare. It is based on an assessment of your health care needs, the recommendation of your provider and your personal preferences.

You may require different services, or more or less of the same services, as your health care needs change. Naturally, this will require that your plan of care change as well. Your Care Management Team and your provider will review and approve changes to your plan of care that is medically necessary. They will periodically evaluate it with you to ensure that the services you are receiving meet your needs. On an annual basis, the PCSP is developed for a year and adjusted as needed based your medical needs.

You are an important member of your health care team, so it is important for you to let us know what you need. Please talk with your provider and Care Management Team if you have a need for any service that you are not currently receiving or wish to change in your plan of care. In addition, your Care Management Team will work with you to make certain that your medical conditions are being properly monitored.

Requesting Changes to the Plan of Care

If you would like to change your plan of care (for example, changing the days or times you receive services) or request a service, such as dental care or optometry, you or your provider should call Member Services to inform your Care Management Team. Your Care Management Team will then consult with your provider about changes you have requested. If your Care Management Team and provider agree, your plan of care will be changed accordingly.

If we have all the necessary information, HomeFirst will respond to your request for changes in your plan of care as quickly as your condition

warrants, but no later than fourteen (14) calendar days for standard requests and seventy-two (72) hours for expedited. If HomeFirst denies your request for change or your request for service, you may appeal the decision. See **Service Authorization, Action and Action Appeals section** (page 47) for instructions on how to appeal an adverse determination by HomeFirst.

Services in Your Plan of Care Requiring Prior Authorization or Concurrent Review

To receive covered services (see page 18), you or your provider must obtain prior authorization from HomeFirst. You can speak to either your Care Management Team or Member Services as described in the **Coordinating Your Care** section on page 14. Member Services can be reached by calling 1-877-771-1119, Monday through Friday, 8:30 a.m. to 5:00 p.m. For TTY/TDD, call 711. Member Services will relay the information to your Care Management Team. If you have Medicare and have any questions about authorizations or coordinating benefits, please contact Member Services at 1-877-771-1119. For TTY, call 711.

All covered services, with the exception of emergency services, require an authorization from HomeFirst prior to obtaining them.

Transportation

HomeFirst does not provide non-emergency medical transportation services as part of the plan's benefits. Transportation services for members is arranged by Medical Answering Services (MAS), the New York State Department of Health statewide transportation broker.

You or your provider must contact MAS at **medanswering.com/** or call 1-844-666 6270 if you reside in the five boroughs of NYC, Nassau,

Westchester or Putnam. Call 1-866-932-7740 if you reside in Dutchess, Orange, Rockland, Sullivan, and Ulster Counties.

Members call in and schedule trips during the hours of Monday through Friday, 7 a.m. to 6:00 p.m. Urgent care visits and hospital discharges can be called in at any time.

You or your doctor should contact MAS at least three (3) days before your medical appointment and provide the details of your appointment (date, time, address, and name of provider) and your Medicaid identification number.

Medical Equipment, Supplies and Oxygen

HomeFirst will arrange for all of your required medical equipment, medical supplies and oxygen. Your Care Management Team will consult with your provider and arrange for delivery and installation. If you already have or need medical equipment that Medicare pays for, HomeFirst will pay your copays for that equipment even if they are from a non-network provider.

Nursing Home Care

Admission to one of our participating nursing homes is made on an individual basis and follows the Medicaid eligibility rules. Your Care Management Team will make arrangements and HomeFirst will cover nursing home care for those members who, along with their provider, agree to a nursing home stay. Members must use Nursing Homes in the HomeFirst provider network.

If you have any questions about nursing home care or your Medicaid or Medicare coverage, please call your Care Management Team.

Service Authorizations, Actions and Action Appeals

When you, or a provider on your behalf, ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request, you or your provider can call Member Services at 1-877-771-1119, Monday through Friday, 8:30 am to 5:00 pm. For TTY, call 711. The request can also be submitted in writing to the following address:

HomeFirst
Attn: Coordinated Care
55 Water Street, 46th Floor
New York, NY 10041

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

Qualified clinical personnel will determine if a service is medically necessary and appropriate based on a comprehensive assessment of your current condition. The service authorization process begins with your initial plan of care when you are enrolled. See page 14 for an explanation of the creation of your initial plan of care.

HomeFirst will act to ensure that service authorizations for all members are carried out in accordance with all applicable Federal and State regulations and all decision timeframes are followed. Every HomeFirst member and member designee has the right to request services. HomeFirst staff is available to help you understand the proper timeline for receiving a response to a request and timeframes for processing the request.

You may wish to choose a family member or friend to speak on your behalf. You must inform HomeFirst of the name of your designated

representative. You can do this by calling your Care Management Team or Member Services. We will provide you with a form that you can fill out and sign stating who the representative will be.

Prior Authorization

All covered services, with the exception of emergency services, require a prior authorization (approval in advance) from HomeFirst before you receive them or in order to be able to continue receiving them. For a list of covered services, see page 18.

To get a service authorization, you or your provider must contact HomeFirst at 1-877-771-1119 (TTY: 711). You or your provider can also send the request in writing to the following address:

HomeFirst
Attn: Coordinated Care
55 Water Street, 46th Floor
New York, NY 10041

Services will be authorized in a certain amount and for a specified period of time. This is called an authorization period.

Concurrent Review

You can also ask HomeFirst to get more of a service than you are getting now. This type of a request is called **concurrent review**. This includes a request for Medicaid-covered home health care services following an inpatient hospital stay.

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, which is called an action. These decisions will be made by qualified health care professionals. 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 **expedited (fast track)** process. You or your doctor can ask for an *expedited (fast track)* review if it is believed that a delay will cause serious harm to your health. If your request for an expedited (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.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals you will have if you don't agree with our decision (see the section on Action Appeals on page 47).

Timeframes for prior authorization requests

- **Standard review:** We will make a decision about your request within three (3) work days of when we have all the information we need, but you will hear from us no later than the seven (7) calendar days after we receive your request. We will tell you by the seventh (7th) day if we need more information.
- **Expedited (fast track) review:** We will make a decision and you will hear from us within seventy-two (72) hours. We will tell you within seventy-two (72) hours if we need more information.

Timeframes for concurrent review requests

- **Standard review:** We will make a decision within one (1) work day of when we have all the information we need, but you will hear from us no later than seven (7) days after we received your request.
- **Expedited (fast track) review:** We will make a decision within one (1) workday of when we have all the information we need. You will hear from us within seventy-two (72) hours after we receive your request. We will tell you within one (1) workday if we need more information.

Special timeframes for other requests:

- If you are asking for inpatient rehabilitation services after an inpatient admission, we will make a decision within 1 work day of when we have all the information we need, but no later than seven (7) days after we receive your request. We will tell you by the seventh (7th) day if we need more information.

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

- Write and tell you what information is needed. If your request is in an expedited (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 fourteen (14) calendar days from the end of original timeframe.

If you are not satisfied with our answer, you have the right to file an action appeal with us. If your internal appeal is decided and the decision is not in your favor, you can request a fair hearing with the New York State Office of Temporary and Disability Assistance (OTDA). See the section on Action Appeals on page 54 for additional 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 Member Services at 1-877-771-1119 or writing by submitting the request to:

HomeFirst
Attn: Coordinated Care
55 Water Street, 46th Floor
New York, NY 10041

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 HomeFirst 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 ten (10) calendar days before we intend to change the service except when:

- the period of advance notice is shortened to five (5) calendar days in cases of confirmed member fraud; or
- we may mail notice not later than date of the Action for the following:
  - the member's death;
  - a signed written statement from you requesting service termination or giving information requiring termination or reduction of services

(where you understand that this must be the result of supplying the information);

– the member's admission to an institution where the member is ineligible for further services;

– the member's address is unknown and mail directed to the member is returned stating that there is no forwarding address;

– the member has been accepted for Medicaid services by another jurisdiction;

– the member's physician prescribes a change in the level of medical care.

If we are checking care that has been given in the past, we will make a decision about paying for it within thirty (30) calendar days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

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 restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

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 sixty (60) days of the date on our letter notifying you of the action.

Contact HomeFirst to File an Appeal

We can be reached by calling 1-877-771-1119 (TTY: 711) or writing to:

HomeFirst
Attn: Appeals and Grievances
55 Water Street, 46th Floor
New York, NY 10041

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file, which includes medical records and other documents used to make the original decision. 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 ten (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.

Your services will continue until you withdraw the appeal, or until ten (10) days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. See **State Fair Hearing** section on page 58.

Although you may request a continuation of services while your appeal is under review, 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 you ask for an expedited (fast track) review, 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 thirty (30) days from the day we receive an appeal. (The review period can be increased up to fourteen (14) days if you request an extension or we need more information, and the delay is in your interest.) You will also have the chance to look at any of 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 an "expedited (fast track)" appeal. See **Expedited (Fast Track) Appeal Process** section below.

Expedited (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 an expedited (fast tracked) review of your appeal of the action. We will respond to you with our decision within seventy-two (72) hours.

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 an expedited (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 an expedited (fast track) appeal within two (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 did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within one hundred twenty (120) days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within ten (10) days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

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 but no later than seventy-two (72 hours) from the date of the plan receives the Fair Hearing decision. 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**) (**otda.ny.gov/hearings/request/**)
- 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: **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 (4) months from the date we denied your appeal.

Here are some ways to get the form:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at **dfs.ny.gov**
- Write the Department of Financial Services at:

New York City – Main Office
New York State Department of Financial Services
One State Street
New York, NY 10004-1511

Albany Office
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257

Contact HomeFirst at 1-877-771-1119 (TTY: 711) if you need help filing an 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 an expedited (fast track) external appeal. The external appeal reviewer will decide an expedited (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

HomeFirst 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 HomeFirst 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 HomeFirst Member Services at 1-877-771-1119 (TTY: 711), or write to:

HomeFirst
Attn: Appeals and Grievances
55 Water Street, 46th Floor
New York, NY 10041

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 (1) of two (2) timeframes:

1. If a delay would significantly increase the risk to your health, we will decide within forty-eight (48) hours after receipt of necessary information, but the process must be completed within seven (7) days of the receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within forty-five (45) days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

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 sixty (60) work days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement 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 complaint decision.

For standard complaint appeals, we will make the appeal decision within thirty (30) work 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 expedited (fast track) complaint appeal process. For expedited (fast track) complaint appeals, we will make our appeal decision within two (2) work days of receipt of necessary information. For both standard and expedited (fast track) complaint appeals, we will provide you with written notice of our decision. 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 HomeFirst. 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: **icannys.org** | Email: ican@cssny.org

If you are not able to resolve your needs within the plan, you can also contact New York State Department of Health and file a complaint at any time by calling 1-866-712-7197, or by writing to:

NYS Department of Health
Bureau of Managed Long-term Care
Suite 1620, One Commerce Plaza
99 Washington Avenue
Albany, NY 12210

Disenrollment from HomeFirst 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 HomeFirst at any time for any reason. To request disenrollment, call Member Services or your Care Management team at 1-877-771-1119 (TTY: 711) or you can write to us. Tell them you wish to disenroll from HomeFirst, and your Care Management Team will work with you and New York Medicaid Choice to ensure you transition safely from our plan to the plan of your choice if you desire to continue to receive long-term care services.

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. If you do not wish to fill it out and request to submit your request to disenroll orally, a HomeFirst representative can fill it out for you.

Completed forms should be submitted to:

HomeFirst
Attn: Coordinated Care
55 Water Street, 46th Floor
New York, NY 10041

Your Care Management Team will discuss your decision with you and help you plan for your care following disenrollment. The date on which your disenrollment from HomeFirst is effective will be the first (1st) day of the month following the month in which the disenrollment is processed through eMedNY.

HomeFirst will forward your request for disenrollment to the LDSS or New York Medicaid Choice from the plan. You will also receive an acknowledgement letter from HomeFirst, confirming your desire to disenroll from the plan.

The disenrollment date will be the last day of the month after LDSS or NY Medicaid Choice has processed the disenrollment and if further services have been arranged if required. Oral requests for disenrollment require the same amount of time to process as written requests. If a request is submitted after the twentieth (20th) of the month, you will be disenrolled by the first (1st) day of the next following month.

Should your discharge plans include a request for future services, the effective date of disenrollment is determined by the LDSS or New York Medicaid Choice, once your request is approved.

For transfers that you make between HomeFirst and another plan, HomeFirst will provide your care through the last day of the month and your new managed long-term care plan will begin your care on the first (1st) day of the next month.

If you require long-term care services and wish to leave HomeFirst, you must choose another plan with NY Medicaid Choice in order to continue to receive your services. You are no longer able to return to Medicaid Fee-for-Service through HRA or LDSS to receive your services.

To summarize, 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 HomeFirst 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 HomeFirst 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 HomeFirst 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. HomeFirst 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 HomeFirst.

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by HomeFirst.

If HomeFirst believes it necessary to disenroll a member involuntarily, we must obtain the approval of the LDSS or NY Medicaid Choice. An eligible member will not be involuntarily disenrolled on the basis of health status. Members that are involuntarily disenrolled may have to be transferred

to another plan to continue to receive personal care and long-term care services. All members will be notified of their fair hearing rights by the LDSS or HRA.

If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) work days from the date we know you meet any of involuntary disenrollment reasons below.

You will have to leave HomeFirst if you:

- Are no longer eligible to receive Medicaid benefits.
- Permanently move out of the HomeFirst service area.
- Are absent from the service area for more than thirty (30) consecutive days.
- Clinically require nursing home care, but you are not eligible for such care under the Medicaid Program's institutional eligibility rules.
- Are hospitalized for forty-five days or longer.
- Enter an Office of Mental Health, Office for People With Developmental Disabilities or the Office of Addiction Services and Supports residential program for forty-five (45) consecutive days or longer.
- Are a non-dual eligible (have Medicaid only) or are a dual eligible member aged 18 to 20 years who is no longer eligible for enrollment because you no longer meet the nursing home level of care based on the assessment tool prescribed by the Department.
- Assessed as no longer having a functional or clinical need for (CBLTSS) for more than 120 days.
- Are receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.

- At any point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Are incarcerated.
- If you knowingly fail to complete and submit any necessary consent or release of information to complete the required assessment.
- Provide HomeFirst with false information, otherwise deceive HomeFirst, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

HomeFirst will provide the LDSS or entity designated by the Department the results of its assessment and recommendations regarding disenrollment within five (5) work days of the assessment making such determination.

We can ask you to leave HomeFirst:

- If you or a member of your family or an informal caregiver engages in conduct or behavior that seriously impairs HomeFirst's ability to furnish services to either you or other members. HomeFirst must make and document reasonable efforts to resolve the problems presented by the individual. HomeFirst may not request disenrollment because of an adverse change in your health or because you need more services, or because of diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs.
- If you fail to pay for or make arrangements satisfactory to HomeFirst to pay the amount owed as a Medicaid surplus to HomeFirst within thirty (30) days after it becomes due, provided that during that thirty-day (30-day) period HomeFirst makes reasonable efforts to collect the amount. The Medicaid surplus amount is determined by HRA and/or your LDSS.

Before being involuntarily disenrolled, HomeFirst 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.

If you are involuntarily disenrolled, HomeFirst will assist your transfer to another managed long-term care plan, Medicaid Managed Care plan (if eligible for Medicaid only) or alternate services.

Cultural and Linguistic Competency

HomeFirst 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

HomeFirst 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 (Bill of 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, color, marital status, race, health status, age, gender identity (including status of being transgender or diagnosed with gender dysphoria), sexual orientation, creed, religion, physical or mental disability, source of payment, type of illness or condition, need for health services, place of origin or with regard to the rate the health plan will receive.

- You have the right to complain to the New York State Department of Health (see contact information on page 64), the NYC Human Resources Administration or Local Department of Social Services; and, the right to use the New York State Fair Hearing System; and, in some instances to request a NYS External Appeal;
- You have the right to appoint someone to speak for you about your care and treatment
- You have the right to make Advance Directives and plans about your care.
- You have the right to seek assistance from the Participant Ombudsman program.

These rights are based on requirements found in PHL 4408, 10 NYCRR 98 1.14, 42 CFR 438.100 and Article 49 of NYS PHL.

The Participant Ombudsman is an independent organization that provides free ombudsman services to long-term care recipients in the State of New York. These services include, but are not necessarily limited to:

- Providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information;
- Compiling member complaints and concerns about enrollment, access to services, and other related matters,
- Helping members understand the fair hearing, complaint and appeal rights and processes within the health plan and at the State level, and assisting them through the process if needed/requested, including making requests of plans and providers for records, and
- Informing plans and providers and community-based resources and supports that can be linked with covered plan benefits.

Member Responsibilities

As with membership in any health care plan, you have certain rights and responsibilities when you join HomeFirst. You'll find a copy of the Member Bill of Rights on page 71 of this handbook. As a member, you also have some responsibilities. These include:

- Receive all of your covered services from the HomeFirst Provider Network.
- Obtain authorization from HomeFirst prior to receiving services subject to review (refer to **Services Authorizations, Action and Appeals** section on page 18).
- Pay HomeFirst any Medicaid surplus that you may have as determined by the New York State Department of Health or the New York City Human Resources Administration.
- Call HomeFirst whenever you have a question regarding your membership or if you need assistance at 1-877-771-1119.
- Tell HomeFirst when you plan to be out of town so we can help you arrange your services.
- Tell HomeFirst when you believe there is a need to change your plan of care.

We want HomeFirst to be the very best managed long-term care plan available. To achieve this goal, we may send you a short survey or call you on the telephone to ask how you feel about the services and care provided by HomeFirst.

Since New York State Medicaid pays HomeFirst, the New York State Department of Health will also be evaluating HomeFirst and our services to see how well we are meeting your needs. We encourage you to participate in the policy development of the organization. If at any time

you believe that you have a suggestion for improving the services, please call 1-877-771-1119 (TTY: 711) or write to:

HomeFirst
Attn: Member Services
55 Water Street, 46th Floor
New York, NY 10041

We value member opinions and would appreciate any comments that you have.

Advance Directives

You have a right to make your own health care decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can prepare for situations when you are unable to make important health care decisions on your own.

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. 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.

There are many different types of Advance Directives:

- Living Will
- Power of Attorney
- Durable Power of Attorney for Health
- Health Care Proxy
- Do Not Resuscitate Orders
- Medical Orders for Life Sustaining Treatment (MOLST)

It is your choice whether you wish to complete an Advance Directive

and which type of Advance Directive is best for you. The law forbids any discrimination against you in medical care based on whether you have an Advance Directive or not.

For more information regarding Advance Directives, please speak with your primary care provider, your Enrollment Representative upon enrollment and/or your Care Management Team. HomeFirst will provide written information about Advance Directives. Forms are available if you wish to complete an Advance Directive. HomeFirst staff is also available to answer questions you may have concerning Advance Directives. If you already have an advanced directive, please share a copy with your care manager.

HomeFirst Funding and Payment

When you enroll, HomeFirst receives a single monthly payment from Medicaid to provide all of the covered services listed on page 18. No premiums, co-payments, or deductibles will be charged to the member.

Payment of Network Providers by HomeFirst

All Network Providers are under contract with HomeFirst and are paid by HomeFirst for the covered services they provide. HomeFirst also has contractual arrangements with delegated vendors who provide services such as dental, vision, and hearing to our members. HomeFirst's providers should never charge you a copay. If you receive a bill directly from a provider, do not pay it and call Member Services at 1-877-771-1119 (TTY: 711), Monday through Friday, 8:30 a.m. to 5:00 p.m., and they will resolve the situation for you.

Surplus (Medicaid Surplus/ Spenddown or NAMI)

Surplus amounts, also referred to as "Spenddown" or Net Available Monthly Income (NAMI), refers to the amount of income LDSS, NYC HRA or entity designated by the Department may determine an individual is required to pay on a monthly basis to meet Medicaid financial eligibility requirements to continue Medicaid coverage. Should LDSS, HRA or entity designated by the Department determine you owe a monthly surplus obligation, HomeFirst is required to bill you for the surplus charges that are determined.

HomeFirst will be notified by LDSS, HRA or entity designated by the Department if the amount of your surplus obligation changes so adjustments can be made accordingly. If necessary, your Care Management Team can discuss this process in detail with you.

Termination for Non-payment

HomeFirst may initiate involuntary disenrollment if a member fails to pay any amount owed as a Medicaid surplus within thirty (30) days after such amount becomes due. HomeFirst will make reasonable efforts to collect the surplus, including written demand for payment and advising the Member about prospective disenrollment. Refer to page 67 or a full explanation of "Involuntary Disenrollment".

Information Available Upon Request

If you would like any of the following information, you or your designated representative can write to:

HomeFirst
55 Water Street, 46th Floor
New York, NY 10041

Simply indicate what documents you are requesting and we will mail them to you within ten (10) work days. Information includes:

- A listing of names, work addresses, and official positions of board members, officers, controlling persons and owners or partners of HomeFirst.
- The policy and procedures to protect members' confidentiality of medical records and other information.
- A written description of HomeFirst's quality assurance plan.
- Information regarding service authorization for a particular disease or condition for the purpose of assisting the member or potential member in evaluating covered services.
- Written application procedures and minimum qualifications for health care providers to be considered by HomeFirst.
- Information on the structure and operation of HomeFirst.
- A copy of the most recent annual certified financial statement of HomeFirst, including a balance sheet and summary of receipts and disbursements prepared by a Certified Public Accountant (CPA).

Electronic Notification

HomeFirst and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

If you select electronic notifications, we make your notices available in your member web portal. You have the choice to get an email and/or text when notices are available in the web portal. Standard text messaging and data rates may apply. If you want to get these notices electronically, you must ask us.

To ask for electronic notices contact us by phone, online, or mail:

Phone 1-877-771-1119

Online notices.homefirst.org

Mail HomeFirst c/o Command Direct
PO Box 18023
Hauppauge, NY 11788

When you contact us, please let us know:

- 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
- Give us your contact information (mobile phone number, email address, fax number, etc).

HomeFirst Notice of Privacy Practices

EFFECTIVE DATE: 9/1/2020

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review it carefully.

This notice summarizes the privacy practices of HomeFirst (the "Plan"), its workforce, medical staff and other health professionals. We may share protected health information ("PHI" or "Health Information") about you with each other for purposes described in this notice, including for the Plan's administrative activities.

The Plan is committed to safeguarding the privacy of our members' PHI. PHI is information which: (1) identifies you (or can reasonably be used to identify you); and (2) relates to your physical or mental health or condition, the provision of health care to you or the payment for that care.

Our Obligations

- We are required by law to maintain the privacy and security of your PHI.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

How We May Use and Disclose Health Information

The following categories describe different ways that we may use and disclose Health Information. Not every use or disclosure permitted in a category is listed below, but the categories provide examples of the uses and disclosures permitted by law.

Payment. We may use and disclose Health Information to process and pay claims submitted to us by you or your physicians, hospitals and other health care providers for services provided to you. For example, other payment purposes may include the use of Health Information to determine eligibility for benefits, coordination of benefits, collection of premiums and medical necessity. We may also share your information with another health plan that provides or has provided coverage to you for payment purposes or for detecting or preventing health care fraud and abuse.

Health Care Operations. We may use and disclose Health Information for health care operations, which are administrative activities involved in operating the Plan. For example, we may use Health Information to operate and manage our business activities related to providing and managing your health care coverage or resolving grievances.

Treatment. We may disclose your Health Information with your health care provider (pharmacies, physicians, hospitals, etc.) to help them provide care to you. For example, if you are in the hospital, we may disclose information sent to us by your physician.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you as a reminder that you have an appointment/visit with us or your health care provider. We also may use and disclose Health Information to tell you about treatment options, alternatives, health-related benefits, or services that may be of interest to you.

By providing us with certain information, you expressly agree that the Plan and its business associates can use certain information (such as your home/ work/mobile telephone number and your email), to contact you about various matters, such as follow-up appointments, collection of amounts owed and other operational matters. You agree you may be contacted through the information you have provided and by use of pre-recorded/ artificial voice messages and use of an automatic/predictive dialing system.

Individuals Involved in Your Care or Payment for Your Care. We may disclose Health Information to a person, such as a family member or friend, who is involved in your medical care or helps pay for your care. We also may notify such individuals about your location or general condition, or disclose such information to an entity assisting in a disaster relief effort. In these cases, we will only share the Health Information that is directly relevant to the person's involvement in your health care or payment related to your health care.

Personal Representatives. We may disclose your Health Information to your personal representative, if any. A personal representative has legal authority to act on your behalf in making decisions related to your health care or care payment. For example, we may disclose your Health Information to a durable power of attorney or legal guardian.

Research. Under certain circumstances, as an organization that performs research, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all members who received one medication or treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits

of research with the need for privacy of Health Information. We also may permit researchers to look at records to help them identify members who may be included in their research project or for other similar purposes.

Fundraising Activities. We may use or disclose your demographic information (e.g., name, address, telephone numbers and other contact information), the dates of health care provided to you, your health care status, the department and physician(s) who provided you services, and your treatment outcome information in contacting you in an effort to raise funds in support of the Plan and other non-profit entities with whom we are conducting a joint fundraising project. We may also disclose your Health Information to a related foundation or to our business associates so that they may contact you to raise funds for us. If we do use or disclose your Health Information for fundraising purposes, you will be informed of your rights to opt out of receiving further fundraising communications.

Special Circumstances

In addition to the above, we may use and disclose Health Information in the following special circumstances. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent or lessen a serious threat to your health or safety, or the health or safety of the public or another person. Any disclosure, however, will be to someone who we believe may be able to help prevent the threat.

Business Associates. We may disclose Health Information to the business associates that we engage to provide services on our behalf if the information is needed for such services. For example, we may use another company to perform billing services on our behalf. Our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.

Organ and Tissue Donation. If you are an organ donor, we may release Health Information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may disclose Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; track certain products and monitor their use and effectiveness; if authorized by law, notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and conduct medical surveillance of our facilities in certain limited circumstances

concerning workplace illness or injury. We also may release Health Information to an appropriate government authority if violence; however, we will only release this information if the member agrees or when we are required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure of our facilities and providers. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Legal Actions. We may disclose Health Information in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in a legal action, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official as follows: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about evidence of criminal conduct on our premises; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. In some circumstances this may be necessary, for example, to determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. In the case of inmates of a correctional institution or individuals that are under the custody of a law enforcement official, we may release Health Information to the appropriate correctional institution or law enforcement official. This release would be made only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Additional Restrictions on Use and Disclosure: Some kinds of Health Information, including, but not limited to, information related to alcohol and drug abuse, mental health treatment, genetic and confidential HIV-related information, require written authorization prior to disclosure and are subject to separate special privacy protections under the laws of the State of New York or other federal laws, so that portions of this notice may not apply.

In the case of genetic information, we will not use or share your genetic information for underwriting purposes.

If a use or sharing of Health Information described above in this Notice is prohibited or otherwise limited by other laws that apply to us, our policy is to meet the requirements of the more stringent law.

Uses and Disclosure Requiring Written Authorization

In situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization:

1) for marketing purposes that are unrelated to your benefit plan,
2) before disclosing any psychotherapy notes,
3) related to the sale of your Health Information, and
4) for other reasons as required by law. For example, State law further requires us to ask for your written authorization before using or disclosing information relating to HIV/AIDS, substance abuse or mental health information.

You have the right to revoke any such authorizations, except in limited circumstance such as if we have taken action in reliance on your authorization.

Your Rights

You have the following rights, subject to certain limitations, regarding Health Information that we maintain about you—all requests must be made IN WRITING:

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information that we use or disclose for treatment, payment or health care operations. You have the right to request a limit on the Health Information that we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, and we may say "no" if it would affect your care. If we agree to your request, we will comply with your request unless we need to use the information in certain emergency treatment situations.

Right to Request Confidential Communications. If you clearly state that the disclosure of all or part of your Health Information could endanger you, you have the right to request that we communicate with you in a certain manner or at a certain location other than through our usual means of communication. For example, you can ask that we contact you only by sending mail to a P.O. Box rather than your home address, or you may wish to receive calls at an alternate phone number. Your request must be in writing and specify how or where you wish to be contacted.

Right to Inspect and Copy. You have the right to inspect and receive a copy of your Health Information that we have in our records that is used to make decisions about your enrollment, care or payment for your care, including information kept in an electronic health record. If you want to review or receive a copy of these records, you must make the request in writing. We may charge you a reasonable fee for the cost of copying and mailing the records. We may deny your access to certain information.

If we do so, we will give you the reason in writing. We will also explain how you may appeal the decision.

Please note that there may be a charge for paper or electronic copies of your records.

Right to Amend. If you feel the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained by or for us. You must tell us the reason for your request.

We may deny your request for an amendment to your record. We may do this if your request is not in writing or does not include a reason to support the request. We also may deny your request if you ask us to amend information that:

- we did not create;
- is not part of the records used to make decisions about you;
- is not part of the information which you are permitted to inspect and
- to receive a copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of Health Information that we made for a six-year (6-year) period. The accounting will only include disclosures that were not made for treatment, payment, health care operations, to you, pursuant to authorization, or for "special circumstances" as outlined in this notice. You are entitled to one Accounting of Disclosures at no charge. Subsequent requests within a twelve-month (12-month) period may be subject to a fee.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at any time from the Plan's website: **elderplan.org/**

How to Exercise Your Rights

To exercise any of your rights described in this notice, other than to obtain a paper copy of this notice, you must contact the Plan.

HomeFirst
Attn: Regulatory Compliance
55 Water Street, 46th Floor
New York, NY 10041
1-800-353-3765 (TTY: 711)

Breach Notification

We will keep your Health Information private and secure as required by law. If there is a breach (as defined by law) of any of your Health Information, then we will notify you within sixty (60) days following the discovery of the breach, unless a delay in notification is requested by law enforcement.

Electronic Health Information Exchange

The Plan may participate in various systems of electronic exchange of Health Information with other healthcare providers, health information exchange networks and health plans. Your Health Information maintained by the Plan may be accessed by other providers, health information exchange networks and health plans for the purposes of treatment,

payment or health care operations. In addition, the Plan may access your Health Information maintained by other providers, health information exchange networks and health plans for treatment, payment or health care operation purposes—but only with your consent.

Changes to This Notice

We reserve the right to change this notice and to make the revised or changed notice effective for Health Information that we already have as well as any information we receive in the future. The new notice will be available upon request, posted on our website, and we will mail a copy to you. The notice will contain the effective date on the first page, in the top left-hand corner.

Complaints and Questions

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact our Privacy Office at the address listed below. All complaints must be made in writing.

HomeFirst
Attn: Regulatory Compliance
55 Water Street, 46th Floor
New York, NY 10041

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

- sending a letter to
  200 Independence Avenue, S.W.
  Washington, D.C. 20201,
- calling 1-877-696-6775, or
- visiting **hhs.gov/ocr/privacy/hipaa/complaints/**.

We will not retaliate against you if you exercise your right to file a complaint. If you have any questions about this notice, please contact 1-855-395-9169 (TTY: 711).

NOTICE OF NON-DISCRIMINATION

Elderplan/HomeFirst complies with Federal civil rights laws. **Elderplan/HomeFirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (as defined in 45 CFR § 92.101(a)(2)).

Elderplan/HomeFirst 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 **Elderplan/HomeFirst** at 1-877-771-1119. For TTY/TDD services, call 711.

If you believe that Elderplan/HomeFirst 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 our Civil Rights Coordinator by:

- Mail: 55 Water Street, 46th Floor, New York, NY 10041
- Phone: 1-877-326-9978 (for TTY/TDD services, call 711)
- Fax: 1-718-758-3643
- In person: 55 Water Street, 46th Floor, New York, NY 10041
- Email: COMPLIANCEDEPT@MJHS.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 **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
- Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**

This notice is available at Elderplan/HomeFirst's website:
elderplan.org/disclaimers/notice-of-nondiscrimination/

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-877-771-1119 (TTY:711).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-877-771-1119 (TTY:711).	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-877-771-1119 (TTY:711)。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 1-877-771-1119 (TTY:711).	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-877-771-1119 (TTY:711) 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-877-771-1119 (TTY:711).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-877-771-1119 (TTY:711).	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-877-771-1119 (TTY:711).	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-877-771-1119 (TTY:711).	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט 1-877-771-1119 (TTY:711) .	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-877-771-1119 (TTY:711).	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-877-771-1119 (TTY:711).	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 1-877-771-1119 (TTY:711)-এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-877-771-1119 (TTY:711).	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-877-771-1119 (TTY:711).	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 1-877-771-1119 (TTY:711)۔	Urdu

elderplan homefirst®

a participating agency of MJHS Health System

55 Water Street, 46th Floor
New York, NY 10041

1-877-771-1119

Monday – Friday
8:30 a.m. – 5:00 p.m

www.homefirst.org