NORTHWEST MISSOURI AREA AGENCY ON AGING
PO Box 265 Albany, Missouri 64402
Phone: 660-726-3800 ~ Fax: 660-726-4113
www.nwmoaaa.org ~ email: nwmoaaa@nwmoaaa.org

Helping People by Lighting the Way

Dear Medicare Beneficiary:

We are happy to provide information to help you make the most informed decision possible about which Medicare Part D plan will best meet your needs.

In order to comply with HIPAA, Federal and State requirements and better assist you, we have enclosed a copy of our Privacy Statement, an Authorization and Consent Form, and an optional Benefit Assessment form, along with the Medicare Part D Worksheet.

Please fill out the Medicare Part D Worksheet form and the Benefit Assessment Form as completely and legibly as possible. You also need to read the Privacy Statement and complete the boxes marked on the Authorization and Consent Form, sign it and send everything, except this memo and the Privacy Statement, back to us for processing.

We will process your information and send you a Plan Comparison which compares the plan you have now with two other plans that should best match your prescription list. If you are new to Medicare, there will be 3 plans for you to compare and make your choice. Instructions will be included about how to enroll, have us enroll you or to make an appointment for additional information and assistance.

Sincerely,

Rebecca J. Flaherty, Chief Executive Officer

NORTHWEST MISSOURI AREA AGENCY ON AGING

Notice of Privacy Practices

Your information, your rights, our responsibilities.

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. **Please read it carefully.**

Your rights. When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you protect them.

Get a copy of your records: (1) You can ask to see or get a copy of your protected health information (PHI) records and other health information we have about you. Ask us how to do this. **(2)** We will provide a copy or a summary of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records: (1) You can ask us to correct your protected health information records if you think they are incorrect or incomplete. Ask us how to do this**. (2)** We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: (1) You can ask us to contact you in a specific way (for example, home or office phone) or send mail to a different address. **(2)** We will consider all reasonable requests and say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share: (1) You can ask us **NOT** to use or share certain protected health information for services, payment or our operations. **(2)** We are not required to agree to your request, and we would say "no" if it would affect your service and make you aware of the consequences of such action.

Get a list of those with whom we've shared information: (1) You can ask for a list (accounting) of the times we've shared your protected health information for six years prior to the date you ask, with whom we shared it and why. **(2)** We will include all the disclosures except for those about payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable cost-based fee if you ask for another one within a 12 month period.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: (1) If you have given someone an appropriate power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. **(2)** We will make sure the person has the authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: (1) You can complain if you feel we have violated your rights by contacting us using the information on the back page. **(2)** You can 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 www.hhs.gov/ocr/privacy/hipaa/complaints. **(3)** We will not retaliate against you for filing a complaint.

Your choices. For certain protected health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: (1) Share information with your family, close friends or others involved in payment for your care. **(2)** Share information in a disaster relief situation. **(3)** If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information to lessen a serious and imminent threat to health or safety.

In these cases, we <u>NEVER</u> share your information unless you give us written permission:
(1) Advertising **(2)** Newsletters/website **(3)** With outside organizations such as Social Security, VA, Family Support Division, etc.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures. How do we typically use or share your protected health information? We typically use or share your protected health information in the following ways:

To provide services: We may use your protected health information to coordinate and manage your care and/or services both within the Agency and with other persons outside the Agency involved in providing care and services to you, such as a provider organization.

To obtain payment: We may use and disclose your protected health information for our own operations and as necessary to provide care and services such as: (1) Assessments and screenings for services and benefits (2) Case management and care coordination (3) Contacting providers and consumers with information about services, care, problem solving and other functions that do not include treatment (4) Professional review and performance evaluation and quality control (5) Review and auditing, including compliance reviews, compliance programs and legal reviews (6) Strategic planning and program development and general administrative activities

For appointment reminders: We may use and disclose your protected health information to contact you as a reminder that you have an appointment or home visit scheduled.

For alternative and referrals: We may use and disclose your protected health information to tell you about or recommend possible service options, benefits or alternatives for which you may be eligible or of interest to you.

How else can we use or share your protected health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues: We can share health information about you for certain situations such as: **(1)** Preventing disease **(2)** Helping with product recall **(3)** Reporting adverse reactions to medications **(4)** Preventing or reducing a serious threat to anyone's health or safety

To report abuse, neglect or domestic violence: As mandated reporters, we are required to report if we suspect you are a victim of abuse, neglect or domestic violence. The Agency would report to the State Elder Abuse Neglect hotline.

Comply with the law: We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Address workers' compensation, law enforcement and other government requests: We can use or share health information about you: **(1)** For workers' compensation claims **(2)** For law enforcement purposes or with a law enforcement official **(3)** With health oversight agencies of activities authorized by law **(4)** For special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our responsibilities. (1) We are required by law to maintain the privacy and security of your protected health information. **(2)** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. **(3)** We must follow the duties and privacy practices described in this notice and offer you a copy of it. **(4)** We will not use or share your protected 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. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the Terms of this Notice: We can change the terms of this notice and the changes will apply to all information we have on file about you. The new notice will be available upon request on our website or we will mail it to you.

NORTHWEST MISSOURI AREA AGENCY ON AGING, 504 E US HWY 136, ALBANY MO 64402
www.nwmoaaa.org rflaherty@nwmoaaa.org 660-726-3800 or 888-844-5626

NORTHWEST MISSOURI AREA AGENCY ON AGING
AUTHORIZATION AND CONSENT FORM

☒ I understand the Northwest Missouri Area Agency on Aging (NWMOAAA) collects information that is considered to be Protected Health Information (PHI) and/or Individually Identifiable Health Information (IIHI) and that in the course of providing services to me, they must enter that information into various secure data bases. They also maintain paper files containing my information. Additional information about the handling of my information is contained in the NWMOAAA Privacy statement which was made available to me. I hereby give my consent to NWMOAAA regarding the data entry and storage of my PHI and/or IIHI.

_____ Initials _____Date

☐ I hereby request and authorize the Northwest Missouri Area Agency on Aging to provide their assessments, my care plan, selection sheets and a letter of authorization to my selected provider.

_____Initials _____ Date

☐ I hereby request and authorize the Northwest Missouri Area Agency on Aging to submit application(s) on my behalf for

_____
_____
_____

☐ I hereby solemnly swear that I have provided true and accurate information to the best of my knowledge for the completion of my application(s). I also understand and agree that if I have provided misinformation with the intent to defraud, the NWMOAAA will not be responsible and will no longer be involved or advocate in such circumstances.

_____Initials _____Date

☒ I acknowledge that I have been offered a copy of the Northwest Missouri Area Agency on Aging's Privacy Statement and had the opportunity to ask questions regarding it.

_____ Initials _____ Date

_____ _____
Signature Date

_____ _____
Personal Representative Relationship

_____ _____
Witness (if applicable) Date

BENEFITS ASSESSMENT FORM

updated 4/1/18

NAME_____ PHONE_____

The numbers below are only guidelines. Individual circumstances and deductions could affect eligibility.

NAME	Monthly Income		Resources		What It Pays For	I am eligible		I have it
	Single	Couple	Single	Couple		Yes	No	
MO HealthNet (Medicaid)	$880	$1186	$2,000	$4,000	Co-Insurance and deductibles for Parts A & B You are auto enrolled in Part D Extra help			
LIS/Extra Help from Social Security	$1,537	$2,077	$14.340	$28,150	Reduces Part D premiums, deductibles, co-pays and eliminates the coverage gap based on income and resource level			
Qualifying Individual- 1 (QI-1)	$1,386	$1,872	$7,560	$11,340	Medicare Part B premium You are auto enrolled in Part D Extra Help			
LIHEAP	$1,556	$2,003	$3,000	$3,000	Funds placed on account to pay for heating			
Food Stamps	$1,307	$1,760	$3,250	$3,250	Funds on EBT Card for food purchase			
Home and Community Based Services (HCBS)	$1,331	NA	$2,000	NA	63 and older, pays for in-home services			
Specified Low-Income Medicare Beneficiary (SLMB)	$1,234	$1,666	$7,560	$11,340	Medicare Part B premium You are auto enrolled in Part D Extra Help			
Qualified Medicare Beneficiary (QMB)	$1,032	$1,392	$7,560	$11,340	Medicare Part A premiums, if applicable Medicare Part B premiums Co-insurance and deductibles for Parts A & B Cost-sharing for Medicare Advantage You are auto enrolled in Part D Extra Help			
Circuit Breaker **Rent** **Own**	**Annual Income** $27,500 $30,000	 $29,500 $34,000	NA	NA	Cash Tax Credit			

CONTACT NORTHWEST MISSOURI AREA AGENCY ON AGING

Website: www.nwmoaaa.org **Call Toll Free: 888-844-5626** **email nwmoaaa@nwmoaaa.org**

Northwest Missouri Area Agency on Aging

"Your trusted source of unbiased information and services since 1973"

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Helping People by Lighting the Way

Not sure which Medicare Part D Plan will meet your needs?

Let us help. Complete both pages of this form *along with any other attached forms* and mail to the above address. We will send you an individual comparison that compares your current plan with two other options, and information on how to enroll in the plan of your choice. If you are new to Medicare, we will include 3 plans for you to compare and make your choice. *Once you receive your comparison from us, you may call toll-free 1-888-844-5626 for further assistance or to schedule an appointment.*

Annual Part D enrollment is **October 15 through December 7**

Name: _____

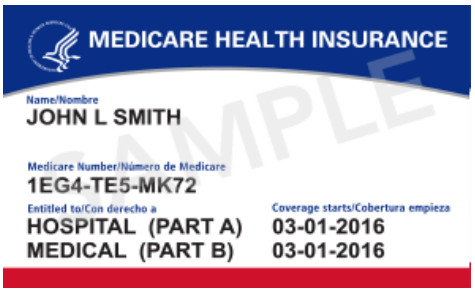
Mailing Address: _____

City: _____ County: _____ Zip Code: _____

Email Address: _____

Phone Number: _____

Medicare Claim # ___ ___ ___ ___- ___ ___ ___-___ ___ ___ ___
(as it appears on new Medicare Card, see example right)



Or ID# if Railroad Retiree _____

Medicare Effective Date:

Part A: ___ ___-___ ___-___ ___ ___ ___ Part B: ___ ___-___ ___-___ ___ ___ ___

Date of Birth (month/day/year): ____ ____-____ ____-____ ____ ____ ____

Where do you have your prescriptions filled: [ ] Local retail pharmacy [ ] Mail order

Pharmacy name:

_____

Do you spend a good portion of the year in another state? [ ] Yes [ ] No

Do you currently have any type of prescription drug coverage? [ ] Yes [ ] No
(including a Medicare Part D plan and/or coverage through an employer or union)
If Yes, what Plan do you have?

_____

Are you on Medicaid or does the State pay your Part B Premium? [ ] Yes [ ] No

If Yes, please enter your Medicaid number: _____

Current Prescription Drugs: **Please double-check spelling** and **include any letters following the drug name,** such as XL, ER, SR, etc. You may also send a printout of your current medications from your pharmacy, and please make sure to **HIGHLIGHT** all your current medicine that you take on a regular basis. Attach a list if more space is needed.

Drug Name (IF GENERIC, WRITE DOWN GENERIC NAME)	Strength of Drug (usually in mg)	How many **TOTAL** pills, inhalers, and vials do you use **PER MONTH**