Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

Health Home Participation(Opt-Out/Decline Services)

Name of Medicaid Beneficiary	Birth Date	Beneficiary's ProviderOne Number
Qualified Health Home Lead	Care Coordination Organization	Managed Care Organization (MCO) if applicable

☐ I have completed a Health Action Plan (HAP) ☐ I have **not** completed a Health Action Plan (HAP)

- I talked with a Care Coordinator who explained the Health Home program and the care coordination services I could get. I have decided not to participate.
- I understand that I will continue to get my other Medicaid health care services.
- If I want Health Home services in the future, I can call: 1-800-562-3022 (TTY/TDD: 711 or 1-800-848-5429)

I am declining services because:

☐ I am happy with my current providers or health care systems.
☐ I do not need any help with my medical and health care needs.
☐ I am not comfortable with using this new benefit or program.
☐ Other – Explain

Details about Protecting your Health Information

When you opt out of Health Home Services the following information is important for you to understand about the health information you have shared with the Care Coordinator:

- Any previously signed Health Home Information Sharing Consent Forms are no longer valid.
- Your health information will be kept by providers/partners who already have your information. They do not have to give it back to you or take it out of their records.
- Your personal health information will still be protected under Washington State and Federal laws and rules. These laws and regulations include Washington State and federal confidentiality rules, RCW 71.05.630, RCW 70.24.105, RCW 70.02, the Uniform Health Care Information Act, 42 CFR 2.31(a)(5), and include 45 CFR Parts 160 and 164, which are the rules referred to as "HIPAA," and 42 CFR Part 2. No one can obtain any new health information about you. Information already shared with others will not be given back.
- If you think a person used your information and you did not agree to give the person permission to use your information, call your Care Coordinator or call the Medicaid Assistance Customer Service Center toll free line at 1-800-562-3022 (TTY/TDD: 711 or 1-800-848-5429).

Beneficiary's Signature or Legal Guardian (if applicable)	Date Signed	If Legal Guardian's Signature, print name

☐ I discussed the Health Home program with the Beneficiary. The benefits were explained; however, they decided not to participate or to end their participation in Health Home.

Signature of the Health Home Care Coordinator	Name of Health Home Care Coordinator	Date Signed

Care Coordinator Instructions

- The Care Coordinator must document the beneficiary's request to opt-out or decline services on this form.
- Remind the beneficiary that the Health Home program is voluntary and to call the number on the form should the beneficiary change their mind in the future.
- The Care Coordinator completes the form and signs on the Care Coordinator signature line.
- If done over the phone, the beneficiary does not need to sign this form, however the Care Coordinator must document the beneficiary's agreement to opt-out or decline services from in the Health Home program.
- Provide a copy of this form to the Beneficiary, Qualified Health Home and/or MCO.

Qualified Health Home / MCO Instructions

Qualified Health Home and MCO's must submit a scanned copy of this completed form in a secure email to HCA at healthhomes@hca.wa.gov within one business day of receipt.