NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Consent Form for NC Medicaid Coverage of Healthy Opportunities Pilot Services

You (the Member of a NC Medicaid health plan) and/or your authorized representative (for example, parent, guardian, or other legally authorized representative) should complete this form with your Care Manager (who may be located at your health plan or doctor's office) or Care Coordinator (at a Human Service Organization). After explaining the form, the Care Manager or Care Coordinator may complete the form for you, if needed.

I. Member Information (* = required)

First Name*

Last Name*

Medicaid ID Number*

Date of Birth*

II. Information About the Healthy Opportunities Pilot Program

The Healthy Opportunities Pilot (HOP) is a program offered by NC Medicaid. If your health plan determines that you are eligible for HOP, you may receive extra benefits that are not normally covered by Medicaid. These benefits would be at no cost to you and include non-medical services that impact health, including food, housing, transportation, interpersonal safety (including services that address violence within the home or community), and toxic stress services (including services that address stress related to abuse or trauma). Your eligibility for, and use of, these services do not have any impact on your ongoing Medicaid eligibility and coverage.

III. Information Sharing

If you are eligible for HOP, the organizations listed on this form will need to share some of your personal health information to make sure you can receive HOP services. The purpose of this form is to obtain your consent to participate in HOP and to allow the North Carolina Department of Health and Human Services and the organizations providing HOP services to send and receive your personal health information as specified in this form.

What Information Will Be Shared?

Your personal health information that may be shared includes: name, Medicaid ID number, date of birth, address, contact information, HOP service eligibility criteria, HOP service authorization number, recommended and/or authorized HOP services, and other personal information. Only the minimum information necessary will be shared with HOP organizations to perform program functions identified in this form.

What Organizations Will Receive My Information and How will it be Used?

The following HOP organizations will access and share your personal health information for the purposes specified below:

- Your care management team to determine your eligibility for HOP, recommend HOP services and provide care management;
- Your Health Plan to authorize your eligibility for HOP and pay for HOP service(s);

- Participating community organizations that deliver HOP services to you and may help determine your eligibility for HOP;
- The Healthy Opportunities Network Lead to assist with invoicing for HOP services and to audit the organizations providing HOP services;
- The Department to administer and audit the HOP program;
- The UNC Cecil G. Sheps Center for Health Services Research to evaluate the HOP program; and
- Organizations within the NCCARE360 network for the purposes of coordinating or providing HOP services, subject to NCCARE360's privacy and security requirements.

I understand the following information about the Healthy Opportunities Pilot (HOP):

1. I have the right to refuse to participate in the HOP program and the right to refuse sharing my personal health information. If I do not consent to participate in HOP and to have my personal health information shared, I will not receive services covered by HOP. My care manager or care coordinator will work with me and try to find other community services to meet my needs, but services offered outside of HOP are subject to availability. Some non-HOP services may not be covered by NC Medicaid, and I may need to pay for those services. My care manager or care coordinator will work with me to try to find services I can afford.
2. If I choose not to participate in HOP or revoke this consent, I will have the option to request to participate in HOP again, at any time, if I am still eligible to receive services.
3. At any time, I may revoke my consent to participate in HOP and/or to have my information shared by contacting my health plan or care manager. If I revoke my consent, no additional information about me will be shared and I will no longer be able to have HOP services paid by Medicaid. However, I understand that disclosures made consistent with and in reliance on my prior consent cannot be revoked and that such information will still be used for the permissible purposes for which the disclosure was made, such as for payment, auditing, or evaluation.
4. Revoking consent to participate in HOP will not affect my rights under my Health Plan to receive treatment, services, or benefits outside of the HOP program. Unless revoked, this consent will end on December 31, 2026.
5. Once I consent to share my personal health information, it may no longer be protected by privacy and confidentiality laws and may be redisclosed by the recipient.

By signing this form, I am voluntarily consenting to participate in the HOP program, if I qualify, and to have my information shared as described in this form. I also consent to have information about the HOP services that I receive stored and exchanged within NCCARE360, for the purposes outlined in this consent form. Further, by signing this form, I confirm that I have read this form, or that it has been read to me, and I understand that a copy of this signed consent will be put in NCCARE360 and I can request a copy for myself.

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If the Member/Authorized Representative is completing this form in person or electronically, please sign and date below.

Name of Person Signing (Member/Authorized Representative)

Member/Authorized Representative Signature Date

Relationship of Person Signing to Member

If the form is being completed and consent obtained telephonically or virtually by the Care Manager or Care Coordinator, the Care Manager or Care Coordinator should read the entire form to the Member/Authorized Representative and complete the information below.

Care Manager or Care Coordinator Signature *(for use only when verbal consent is being obtained telephonically or virtually by the Care Manager or Care Coordinator)*

I, *(Name of Care Manager or Care Coordinator),* on *(Date)* read and discussed the information provided in this form with the member or authorized representative specified below. Further, on *(Month/Day/Year)* at *(Time)* the member or authorized representative specified below provided verbal consent for the member to participate in the Healthy Opportunities Pilot (HOP) and, if the member qualifies, to have their information shared as described in this form.

I have accurately recorded the verbal consent provided to me by the member or authorized representative specified below.

Care Manager or Care Coordinator Signature Name of Organization Date

Name of Individual that Provided Verbal Consent (Member/Authorized Representative)

Relationship of Individual that Provided Verbal Consent