Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Health Home Participation (Opt-Out/Decline Services)

1 Applicant information

Client name

Date of birth

ProviderOne ID 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)

- The Health Home program has been explained to me and I have decided not to participate.
- I understand that I will continue to get my other Apple Health (Medicaid) services.
- If I want Health Home services in the future, I can call: 1-800-562-3022 (TRS: 711)

I am declining services because:

☐ My benefits and services work for me.

☐ I do not need any help with my medical and health care needs.

☐ I am not comfortable with using this benefit or program.

☐ Other
Explain _____

2 Protecting your health information

When you opt out of Health Home services the following information is important for you to understand:

- Any previously signed Health Home Information Sharing Consent Forms are no longer valid.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 Apple Health customer service at 1-800-562-3022 (TRS: 711)

3 Client signature

Client signature or authorized representative (if applicable)

Date signed

Print authorized representative's name (if applicable)

4 Health Home Care Coordinator

☐ I discussed the Health Home program with the client or authorized representative. The benefits were explained and they decided not to participate or to end their participation in Health Home.

Signature of the Care Coordinator or Allied Staff

Date signed

Name of Care Coordinator or Allied Staff

5 Care Coordinator or Allied Staff instructions

The Care Coordinator or Allied Staff is responsible for:

- Documenting the client's request to opt-out or decline services, on this form and in the client's case file.
- Signing on the *Signature of the Care Coordinator* or *Allied Staff* line after the form has been completed. If the client's request to opt-out or declines services is made over the phone, the client does not need to sign this form and the Care Coordinator or Allied Staff must document the request on their behalf.
- Providing the client a copy of the form, in person or by mail.
- Ensuring that the Qualified Health Home Lead or MCO is provided with a copy of the form.

6 Qualified Health Home Lead or MCO instructions

The Qualified Health Home Lead or MCO must maintain this form and document on the Health Home Opt-Out Form Registry, for monthly submission to the Health Care Authority.