Family Health Network
Member Handbook
Providing Healthcare to Illinois Participants in All Kids, FamilyCare, Moms & Babies, Eligible Adults

If you prefer this handbook in Spanish, call 1.888.346.4968 and request a Spanish version
Si usted prefiere este documento en Español, llame al: 1.888.346.4968 y pida la versión en Español.
Welcome to Family Health Network

Discover the Family Health Network Difference

Family Health Network (FHN) is a not-for-profit managed health plan in Illinois. Family Health Network is sponsored by hospitals in the community. Our doctors and health care providers meet strict standards and will give you and your children quality medical care.

Family Health Network provides you with all the same services covered by the State’s Primary Care Case Management Program (PCCM). We also have many extra benefits. Please call Member Services (1.888.346.4968) for a listing of these extra benefits. Family Health Network is dedicated to you, your family, and to the community.

We know you’ll discover the Family Health Network quality difference and benefit from your membership.

Family Health Network Contact Information:

Member Services: 1.888.346.4968
TTY for the Hearing Impaired: 1.800.422.1942
Website: www.fhnchicago.com
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FHN serves people living in the Chicago area including: Cook, DuPage, Kane, Kankakee, Lake and Will Counties. FHN also serves people living in the Rockford area including: Boone, McHenry and Winnebago counties.

We have a dedicated staff of skilled member service representatives to help you. Call 1.888.346.4968 (toll free) to speak with a member of our staff. We have representatives that speak both English and Spanish.

Our staff will:
• give you a welcome call
• answer questions
• help you choose a new doctor
• arrange for transportation to your doctor visits
• help you make appointments
• send you new FHN ID cards
• make extra benefits ready to you
• help you touch base with your care manager, social worker, or nurse

Did you change your address or phone number? Always reach out to Member Services at: 1.888.346.4968. We need to know where you live to send you information about extra benefits and rewards.

Member ID Card
Each member of Family Health Network will get a Member ID Card. Always carry it with you. The card has the name, phone number and address of the doctor you have chosen, as well as important pharmacy information.

You will also get an HFS Medical Card from the State.

Remember to always carry your Family Health Network ID Card AND your HFS Medical Card with you at all times.
Your Doctors

• Primary Care Physician (PCP)
• Women’s Health Care Provider (WHCP)

When you joined FHN, you also chose a primary care physician (PCP). You can choose a different PCP for each family member. Your PCP can be a:

• Family Practice Doctor who cares for people of all ages.
• Pediatrician, a doctor who mainly cares for children.
• Internal Medicine, a doctor who cares mostly for adults.
• General Practice Doctor, who does not have special training and takes care of both children and adults.

Your PCP is your personal doctor

He or she will arrange all of your health care needs. This involves preventive care and referring you to a specialist. Your PCP will also arrange for your lab and X-Ray tests and Family Planning. Your PCP will admit you to the hospital when needed.

Female members can also choose a Women’s Health Care Provider (WHCP)

A Women’s Health Care Provider is a doctor who works in Obstetrics and Gynecology or Family Practice.

If your doctor is not a WHCP you may want to choose one. You may do so at any time. You don’t have to choose a WHCP if you don’t want to.

You don’t need a referral from your PCP to see your WHCP. But your PCP and WHCP must have a referral arrangement with each other. Your WHCP also needs to be a part of the FHN network.

To get a list of in-network WHCP’s call Member Services. The phone number to call is 1.888.346.4968. You will get the list within ten business days of your call.

If you need help choosing a doctor or WHCP call Member Services at 1.888.346.4968.

IMPORTANT...you will need to get all of your health care services through your Family Health Network Primary Care Doctor or WHCP. If you do not get care from your FHN doctor, we may not pay for that service (except for emergencies and family planning).
Your Doctors

Changing Your Doctor

Changing your doctor (PCP or WHCP) is easy. Call Member Services and they will help you. This may be very important if you move and want a doctor closer to your home. It may take up to 30 days to change your doctor. You will be sent a new Member ID Card with your doctor’s name and phone number on it.

Contacting Your Doctors (PCP or WHCP)

You can call your doctor 24 hours a day, 7 days a week. If your doctor is not on hand, he or she will have a “doctor on call” who will care for you. The phone number for your doctor is printed on the front of your Member ID Card. Remember to carry your Member ID Card with you at all times.

Specialty Care

Your Primary Care Doctor can take care of most of your health care needs. Your doctor may want you to see a specialty doctor. Your doctor will give you a written referral form for the specialty doctor. They will help you make the appointment. Take the referral form to the specialty doctor. Mental Health and Substance Abuse Services can be given by any Family Health Network approved provider without a referral from your Primary Care Physician. You can use Family Planning Services in-network and out-of-network without a referral from your Primary Care Physician. Family Planning services are FREE.

Second Opinion

Your doctor may want you to have surgery or diagnose you with a serious health problem. You may want to talk about this with one more doctor. If you do, you have the right to ask for a second opinion. Please call member services to ask for a second opinion. FHN will find a doctor in-network to help you. 1.888.346.4968

Transition Care

If you are a new enrollee and are in a treatment plan by a doctor who is not with Family Health Network, you can ask to keep seeing that doctor for up to ninety (90) days after becoming a member of Family Health Network under these conditions:

• You must keep seeing the same doctor regularly for treatment of the specific health problem or disease.

• You are in your seventh, eighth, or ninth month of pregnancy. You can ask to keep your doctor until after the baby is born and the follow-up care is done.

• Your doctor agrees to follow the Family Health Network policies and payment.

To ask for Transition of Care Services, call Family Health Network Member Services at 1.888.346.4968 and they will help you if your care can be transitioned to an in-network provider safely.
Family Health Network provides members all the same services covered by the State’s Primary Care Case Management Program (PCCM). We also offer a wide range of extra benefits and rewards. Below is a list of some of the medical services covered. The Complete list can be found on our website at www.fhnchicago.com.

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Assistive/Augmentative communication devices;
- Audiology services;
- Blood, blood components and the administration thereof;
- Chiropractic services for Enrollees under age twenty-one (21);
- Dental services, including oral surgeons;
- EPSDT services for Enrollees under age twenty-one (21) pursuant to 89 Ill. Admin. Code Section 140.485; excluding shift nursing for Enrollees in the MFTD HCBS Waiver for individuals who are medically fragile and technology dependent (MFTD);
- Family planning services and supplies;
- FQHCs, RHCs and other Encounter rate clinic visits;
- Home health agency visits;
- Hospital emergency room visits;
- Hospital inpatient services; Hospital ambulatory services;
- Laboratory and x-ray services (Contractor shall receive and transmit electronic lab values to support clinical management and for HEDIS® reporting);
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- Mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option, and Targeted Case Management Option;
- Nursing care for Enrollees under age twenty-one (21) not in the HCBS Waiver for individuals who are MFTD, pursuant to 89 Ill. Admin. Code Section 140.472;
- Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Enrollees under age twentyone (21), pursuant to 89 Ill. Admin. Code 146, Subpart D;
- Nursing Facility services
- Optical services and supplies;
- Optometrist services;
- Palliative and Hospice services;
- Pharmacy Services (drugs used in the treatment of Hepatitis C are covered only if dispensed in accordance with Contractor’s coverage criteria approved by the Department);
- Physical, Occupational and Speech Therapy services;
- Physician services;
- Podiatric services for Enrollees under age 21;
- Podiatric services for diabetic Enrollees age 21 and over, and, effective October 1, 2014, podiatric services for all Enrollees age 21 and over;
- Post-Stabilization Services as detailed in Section 5.17.2 of this Contract;
- Renal Dialysis services;
- Respiratory Equipment and Supplies;
• Services to prevent illness and promote health in accordance with Attachment XXI
• Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390, 77 Ill. Admin. Code Part 2090, Day treatment (residential) and Day treatment (detox);
• Transplants covered under 89 Ill. Admin. Code Section 148.82 (using transplant providers certified by the Department) and
• Transportation to secure Covered Services.

For a complete listing of covered services under Long-Term Services and Supports please see page 22.

**Extra Benefits**

- **Transportation** arranged by FHN for all your covered services
- **No Co-Payments** for doctor visits, emergency room, hospital services and covered prescriptions
- **Brighter Beginnings** for pregnant women and babies
- **FREE Adult Dental Services including:**
  - Periodic oral exam and dental cleaning every 6 months
  - Root planning and scaling for gum disease once per lifetime
  - Periodontal maintenance and cleaning procedure every 6 months
- **FREE Cough, Cold, Allergy Medicines and Vitamins** prescribed by your doctor
- **$40 Adult Vision Rebate** for frames and/or contacts from licensed providers
- **Toddler Book Club** for children ages 3-4
- **Children’s Book Club** for children ages 5-16
- **FREE Weight Watchers® Membership**
- **Discounted Curves® Membership**
- **NurseNow** 24-hour help hotline
- **Monthly Newsletters**
- **FREE Pregnancy Test Kits**
- **FREE Jewel-Osco Coupons** to use on any Equaline Product (limit 5 per month).

**Get Rewards Just for Staying Healthy**

- **$10 Gift Cards** for prenatal visits
- **$25 Gift Card** for postpartum visit and depression screening
- **$25 and $50** reward for well child visits for babies under 15 months
- **Diaper Program** for keeping children’s immunizations up to date
- **Mammography Program** for women, age 40 and over, who receive annual mammograms
- **Graco Pack ‘n Play** for missing no more than one required prenatal visit
- **$25 Incentive Card** for Care Coordination Program
Emergencies can happen. Learn what to do. In case of an Emergency Health Issue you should: **Go to the closest ER or to the nearest FHN network hospital OR Call 911 for help.**

Family Health Network will cover services provided for an Emergency Health Issue no matter where you are. You must have someone call FHN within 24 hours or as soon as reasonably possible. **Call 1.888.346.4968 to report an emergency hospital admission.** When the health condition is stable, you may be moved to a Family Health Network Hospital.

After an Emergency Health Issue, you must get all follow-up care through your Primary Care Doctor as soon as possible.

**Examples of an Emergency Health Issue are:**
- Heavy, uncontrollable bleeding
- Extreme pain
- Chest pain
- Bad burns
- Black out
- Problems breathing
- Slurred speech
- Shock
- Poison
- Seizure or extreme bodily shaking
- Miscarriage
- Broken bones
- Throwing up blood

**Urgent Care**

Urgent Care means you need health care soon, but it is not a crisis. Call your doctor. Do not wait for a normally scheduled appointment. The name and number of your doctor are on the front of your Member ID Card. Call your doctor. He or she will check your health issue and see you within 24 hours, if needed.

**Examples of an Emergency Health Issue are:**
- Ear aches
- Skin infections
- Minor burns or cuts
- Blistered sunburn
- Bad cold or sore

**Hospitalization**

If you need to go to a hospital, your doctor will send you to an FHN hospital. To be covered by the Family Health Network, all hospital care must be referred by your Family Health Network doctor and approved by Family Health Network.
Mental Health and Substance Abuse Services

If you need mental health and/or substance abuse services, they can be given by any Family Health Network approved provider without a referral from your primary care physician. To get help call PsychHealth. The phone number to call is 1.800.753.5456.

Prescriptions

Your prescriptions are paid for by Family Health Network. CVS Caremark is the group that provides your drugs. You do not have to go to a CVS store.

There are over 1,000 in-network drugstores. Some of these are:

- Clinics
- Neighborhood drug stores
- Hospital out-patient drugstores
- CVS
- Walgreens
- Jewel-Osco
- Target
- Sam’s Club
- Costco

You should take your FHN card with you to the drugstore. You will not be asked to pay a co-pay. To find an in-network drugstore, call CVS Caremark Customer Service. The number to call is 1.855.293.4114.

Making Appointments

Make appointments with your Primary Care Doctor. This is your normal doctor. This is where your health records are kept.

- If you need to cancel your appointment, call your doctor’s office.
- If you are going to be late for your appointment, call the doctor’s office to let them know. They may ask you to set up a new appointment time.

NEW MEMBERS SHOULD MAKE THEIR FIRST APPOINTMENT NOW!

If you picked a new doctor when you joined Family Health Network, you should call and make an appointment to meet the doctor. The phone number of your doctor is on your Member ID Card. You should make separate appointments for each member of your family.

When You Make an Appointment, it’s Important to:

- Have your Member ID Card with you.
- Make clear why you need an appointment.
- Make an appointment for each person in your family who needs to be seen.
- Tell the doctor’s office if you need urgent care so you can be seen within 24 hours.

Transportation

If you need a ride to the doctor, call Member Services. The phone number to call is 1.888.346.4968. You must call more than one business day before your appointment to get a ride. Siblings or significant others may go with you to an appointment as needed.
**Important Family Health and Network Services**

Your Family Health Network doctor will help you get the care you need. A full list of covered services is found in the Certificate of Coverage. You can ask for a copy by calling Member Services. The phone number to call is 1.888.346.4968. You can also find it online at www.fhnchicago.com

**Preventive Services and Health Education**

Family Health Network wants to keep you and your children healthy. You may get your children’s immunizations, medical exams and care through Family Health Network. Family Health Network hospitals will have special events to which you will be invited. These will involve special programs for your children and special health education classes.

**Care Management and Disease Management**

We want to help you manage your long-term health issues. Do you have asthma, diabetes or some other type of long-term health issue? Then you may benefit from care management. Family Health Network Care Management helps you take care of your health. You will get one-on-one help from your own Care Coordinator. Your Care Coordinator will teach you how to control your disease. You will learn how to eat, exercise and take your medicine. Care Management gives you the training you need to be healthy. You will also have access to nurses, doctors and the health care you deserve.

We want to help improve your health. Please call 1.888.346.4968 and ask for FHN Care Management.

**Obstetric Services (if you become pregnant)**

If you think you are pregnant, call your doctor soon. See your doctor early in pregnancy. We want you to have a healthy baby. When you are pregnant see your doctor at least:

- Every 4 weeks during the first 6 months.
- Every 2 weeks during the 7th and 8th months.
- Every week during the last month.

It is very important you do NOT travel outside FHN’s service area during the last month of your pregnancy. Routine delivery outside the contracting area is not covered. If you leave the service area during your third trimester, talk to your doctor first or call Family Health Network for information. Family Health Network may not pay for your delivery if you are outside the service area.

Eat healthy food. Do NOT smoke when you are pregnant. Do NOT drink alcohol while you are pregnant. Do NOT use any meds or drugs unless you ask your doctor. If you need food, go to a WIC Center. For a list of WIC sites near you, call the Public Health Hotline at 1.800.545.2200. If you need other special help, call Member Services at 1.888.346.4968. We will try to help you.

**Join Brighter Beginnings**

If you are pregnant, or think you may be pregnant, call Member Services at: 1.888.346.4968. There are many rewards for you when you are pregnant and see your doctor regularly.

The first well-baby visit is in the hospital and the second well-baby visit is at 2 weeks of age. After that you should take your baby to the doctor for exams and shots. Choose a doctor for your new baby as soon as you get back home. Call member services at 1.888.346.4968.
Set up appointments for your baby’s well-baby visits at ages:
1, 4, 6, 9, 12, 15, and 24 months

Well Baby Care

Babies need to see a doctor every 2-3 months in their first year – even if they are not sick. At the well-baby visits your doctor will:

- Give shots that will protect your baby from serious illnesses.
- Make sure your baby is growing the right way.
- Point out problems that may call for special care.
- Guide you in feeding and helping your baby fall asleep.
- Answer any questions to help you care for your baby.

Well Child Visit Program

FHN rewards members who take their baby to the doctor. Members can get a:

- $25 incentive card for the first well-child visit for the newborn
- $50 incentive card for six well-child visits for the baby by 15 months of age

Immunizations for Babies

These are the shots your baby needs:

<table>
<thead>
<tr>
<th>Age</th>
<th>Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Birth</td>
<td>HepB</td>
</tr>
<tr>
<td>2 Months</td>
<td>HepB (1-2 months) + DTaP + PCV + Hib + Polio + Rv</td>
</tr>
<tr>
<td>4 Months</td>
<td>HepB2 + DTaP + PCV + Hib + Polio + Rv</td>
</tr>
<tr>
<td>6 Months</td>
<td>HepB (6-18 months) + DTaP + PCV + Hib3 + Polio (6-18 months) + Rv + Influenza (6-59 months)</td>
</tr>
<tr>
<td>12 Months</td>
<td>MMR + DTaP + PCV + Hib + Chickenpox + HepA + Influenza or older (12-15 mos) (15-18 mos) (12-15 mos) (12-15 mos) (12-23 mos) (6-59 months)</td>
</tr>
</tbody>
</table>

Check with your doctor or nurse to make sure your baby is getting all shots on schedule. Many times vaccines are mixed to cut the number of shots. Be sure you ask for a record card with the dates of your baby’s shots; bring this with you to every visit.

Here’s a list of the illnesses your baby will be guarded against:

- HepB: hepatitis B, a serious liver disease
- DTaP: diphtheria, tetanus (lockjaw), and pertussis (whooping cough)
- PCV: pneumococcal conjugate vaccine protects against a serious blood, lung, and brain infection
- Hib: Haemophilus influenzae type b, a serious brain, throat, and blood infection
- Polio: a serious paralyzing disease
- Rv: rotavirus infection, a serious diarrheal disease
- Influenza: a serious lung infection
- MMR: measles, mumps, and rubella
- HepA: hepatitis A, a serious liver disease
- Chickenpox: also called varicella

Footnotes to above chart:
1. This is the age range in which this shot should be given.
2. Your baby may not need a dose of Hep B vaccine at age 4 months based on the type of shot that your health care provider uses.
3. Your baby may not need a dose of Hib vaccine at age 6 months based on the type of shot that your health care provider uses.
4. All children between the ages of 6 and 59 months should get a shot for the flu in the fall of each year. First-time vaccines should get 2 doses, separated by at least 4 weeks.
5. This dose of DTaP may be given as early as 12 months if it has been 6 months since the last dose and if you think you might not return for more shots by the time your child is age 18 months.
**Member Rights**

**FHN Members have the right to:**

- Be treated with dignity and respect.
- Get care consistent with sound nursing and health care practices.
- Privacy during a visit with their FHN doctor.
- Get an explanation of their illness and choices in a manner appropriate to their health issue and ability to grasp, as well as the ability to ask for a second point of view.
- Share in deciding the type of care they will get. Persons under 18 who are married, pregnant, or have a child also have this right.
- Say no to health care (to the extent of the Law) and grasp what may happen if they choose not to get care.
- Ask for information about MCO and health care facility licensure.
- Ask for information about providers of health care services, as well as schooling, board certification, and re-certification.
- Ask for information about doctor bills and payments.
- Make a “living will” to plan for the kind of care they want if they become seriously ill or hurt.
- Talk about their medical records with the FHN doctor and ask for a summary of their records.
- Have access to, get a copy of, and have their health records changed or fixed in line with federal and state laws.
- Expect their records to be treated in secret and to not be released without their go-ahead.
- Get information about Family Health Network, its services and providers.
- Choose a family doctor from the FHN network and to switch to another FHN doctor at any time.
- Make a complaint to FHN, or file a grievance and get an answer within 10 days after a grievance hearing.
- Not to be terminated from FHN due to high use of services, diminished mental skill, or hard to handle/disruptive behavior due to the member’s special needs.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To be free to put in use these rights and the exercise of these rights does not make worse the way FHN treats members.
- Not be terminated from FHN due to actions in connection with appeal or grievance rights.

*To learn more about your Health Plan choices please contact Illinois client Enrollment Services at 1.877.912.8880 or visit www.EnrollHFS.Illinois.gov.*
**Member Responsibilities**

- Treat doctors, staff, and FHN workers with dignity and respect.
- Make and keep appointments and be on time. A member will always call with as much notice as possible if they need to cancel an appointment or if they will be late.
- Get referrals from their FHN doctor before going to a specialist, hospital, or some other health care provider.
- Tell their FHN doctor as soon as possible after getting emergency room services.
- Make clear their health problem and symptoms to the doctor and to ask questions.
- Follow their doctor’s treatment plan.
- Talk with their FHN doctor about any events that could keep them from following doctor’s orders.
- Become involved in their health care – get the information they need to take part in any treatment decisions.
- Think over the result of refusing treatment recommended by a doctor.
- Learn and follow the FHN policies in their Member Handbook.
- Carry their FHN ID card with them at all times and right away report any lost or stolen cards to one of the FHN Member Services Representatives.
- Call one of the FHN Member Services Representatives if they have a problem and need help.
- Respect the privacy of other people waiting to get health care services.
- Make a “living will” to tell their wishes about any type of care they want if they become seriously ill or hurt.

**Compliance**

Family Health Network has a compliance plan in place to protect your privacy and identify potential fraud, waste and abuse of the Medicaid program benefits. If you become aware of any possible compliance issues or any fraud, waste and abuse issues please contact us at 1.312.880.1625.
Disenrollment Procedures

You can change your health plan within 90 days from the effective date of your enrollment. You also have another chance to change plans during your Open Enrollment at the end of the 12 month lock-in period. To do so, call Member Services at: 1.888.346.4968. You can also call the Client Enrollment Services at: 1.877.912.8880 to change medical plans.

If you have been disenrolled from Family Health Network due to loss of eligibility, call the Client Enrollment Services.

Advance Directives

A living will is a paper that tells your Primary Care Doctor and family how you want to be taken care of if you cannot speak for yourself. It is a legal paper to write down what medical care you want. If you have questions, talk to your Primary Care Doctor or call Member Services at 1.888.346.4968.

MCO Program – Grievances and Appeals

We want you to be happy with services you get from Family Health Network and our providers. If you are not happy, you can file a grievance or appeal.

Grievances

A grievance is a complaint about any matter other than a denied, reduced, or terminated service or item.

FHN takes member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, you should let us know right away. FHN has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits coverage.

These are examples of when you might want to file a grievance.

- Your provider or an FHN staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or an FHN staff member was rude to you.
- Your provider or an FHN staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling FHN at 888.346.4968. You can also file your grievance in writing via mail or fax at:

Family Health Network
Attn: Grievance and Appeals Dept.
322 S. Green Street, Suite 400, Chicago, IL 60607
Fax Number: 1.312.738.3116
In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling 1.888.346.4968.

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your grievance. If you are hearing impaired, call the Illinois Relay at 711.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, fill out the Authorized Representative Form for Grievance and Appeals listed on our website.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

**Appeals**

You may not agree with a decision or an action made by FHN about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within sixty (60) calendar days of the date on our Notice of Action form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than ten (10) calendar days from the date on our Notice of Action form. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not advising you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a “Notice of Action” letter from us. This letter will tell you the following:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services

Here are two ways to file an appeal:

1) Call Member Services at 1.888.346.4968. If you file an appeal over the phone, you must follow it with a written signed appeal request.

2) Mail or fax your written appeal request to:

   **Family Health Network**
   **Attn: Grievance and Appeals Dept.**
   **322 S. Green Street, Suite 400, Chicago, IL 60607**
   **Fax Number: 1.312.738.3116**

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your appeal. If you are hearing impaired, call the Illinois Relay at 711.
**Can Someone Help You with the Appeals Process?**

You have several options for assistance. You may:
- Ask someone you know to assist in representing you. This could be your Primary Care Physician or a family member, for example.
- Choose to be represented by a legal professional.
- If you are in the Disabilities waiver, Traumatic Brain Injury waiver, or HIV/AIDS waiver, you may also contact Client Assistance Program (CAP) to request their assistance. The phone number to call is 1.800.641.3929 (voice) or 1.888.460.5111 (TTY).

To appoint someone to represent you, fill out the Authorized Representative Appeals form. You may find this form on our website at: http://www.fhnchicago.com/memberforms.html.

**Appeal Process**

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

FHN will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. FHN may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Decision Notice. The Decision Notice will tell you what we will do and why.

If FHN’s decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If FHN’s decision does not agree with the Notice of Action, we will approve the services to start right away.

Things to keep in mind during the appeal process:
- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when FHN reviews your appeal.

How can you expedite your Appeal?

If you or your provider believes our standard timeframe of fifteen (15) business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Action letter, information about your case, and why you are asking for the expedited appeal. We will let you know within twenty-four (24) hours if we need more information. Once all information is provided, we will call you within twenty-four (24) hours to inform
of our decision and will also send you and your authorized representative the Decision Notice.

How can you withdraw an Appeal?
You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

FHN will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call FHN at 888.346.4968.

What happens next?
After you receive the FHN appeal Decision Notice in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing Appeal and/or asking for an External Review of your appeal within thirty (30) calendar days of the date on the Decision Notice. You can choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within thirty (30) calendar days of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within ten (10) calendar days of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the FHN Appeals process, you may ask someone to represent you, such as a lawyer, or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

You can ask for a State Fair Hearing in one of the following ways:

• Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.

• If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly waiver (Community Care Program (CCP)) services, send your request in writing to:

  Illinois Department of Healthcare and Family Services, Bureau of Administrative Hearings, 69 W. Washington Street, 4th Floor, Chicago, IL 60602
  Fax: 1.312.793-2005, Email: HFS.FairHearings@illinois.gov, Or you may call 1.855.418.4421, TTY: 1.800.526-5812

• If you want to file a State Fair Hearing Appeal related to mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Services Program (HSP) service, send your request in writing to:

  Illinois Department of Human Services, Bureau of Hearings, 69 W. Washington Street, 4th Floor, Chicago, IL 60602
  Fax: 1.312.793.8573, Email: DHS.HSPAppeals@illinois.gov, Or you may call 1.800.435.0774, TTY: 1.877.734.7429
**State Fair Hearing Process**

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings office informing you of the date, time, and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully.

At least three (3) business days before the hearing, you will receive information from FHN. This will include all evidence we will present at the hearing. This will also be sent to the Impartial Hearing Officer. You must provide all the evidence you will present at the hearing to FHN and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal. You will need to notify the appropriate Hearings Office of any accommodation you may need. Your hearing may be conducted over the phone. Please be sure to provide the best phone number to reach you during business hours in your request for a State Fair Hearing. The hearing may be recorded.

**Continuance or Postponement**

You may request a continuance during the hearing, or a postponement prior to the hearing, which may be granted if good cause exists. If the Impartial Hearing Officer agrees, you and all parties to the appeal will be notified in writing of a new date, time and place. The time limit for the appeal process to be completed will be extended by the length of the continuation or postponement.

**Failure to Appear at the Hearing**

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date, and place on the notice, and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

Your hearing may be rescheduled, if you let us know within ten (10) calendar days from the date you received the Dismissal Notice, if the reason for your failure to appear was:

- A death in the family
- Personal injury or illness which reasonably would prohibit your appearance
- A sudden and unexpected emergency

If the appeal hearing is rescheduled, the Hearings Office will send you or your authorized representative a letter rescheduling the hearing with copies to all parties to the appeal. If we deny your request to reset your hearing, you will receive a letter in the mail informing you of our denial.

**The State Fair Hearing Decision**

A Final Administrative Decision will be sent to you and all interested parties in writing by the appropriate Hearings Office. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as thirty-five (35) days from the date of this letter. If you have questions, please call the Hearing Office.
**External Review**

Within thirty (30) calendar days after the date on the FHN appeal Decision Notice, you may choose to ask for a review by someone outside of FHN. This is called an external review. The outside reviewer must meet the following requirements:

- Board certified provider with the same or like specialty as your treating provider
- Currently practicing
- Have no financial interest in the decision
- Not know you and will not know your identity during the review

External review is not available for appeals related to services received through the Elderly Waiver; Persons with Disabilities waiver; Traumatic Brain Injury waiver; HIV/AIDS waiver; or the Home Services Program.

Your letter must ask for an external review of that action and should be sent to:

**Family Health Network**  
Attn: Grievance and Appeals Dept.  
322 S. Green Street, Suite 400, Chicago, IL 60607  
Fax Number: 1.312.738.3116

**What Happens Next?**

- We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.
- You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and FHN a letter with their decision within five (5) calendar days of receiving all the information they need to complete their review.

**Expedited External Review**

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an expedited external review. You can do this over the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at 888.346.4968. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

**Family Health Network**  
Attn: Grievance and Appeals Dept.  
322 S. Green Street, Suite 400, Chicago, IL 60607  
Fax Number: 1.312.738.3116
**What Happens Next?**

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will also send the necessary information to the external reviewer so they can begin their review.
- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and FHN know what their decision is verbally. They will also follow up with a letter to you and/or your representative and FHN with the decision within forty-eight (48) hours.

**Other Important Information**

You may request information as to how your doctor makes referrals. You can write a request for information on incentive plans and reinsurance protection. Your doctor may exercise “Right of Conscious” and not provide certain medical services. If so, call Member Services and FHN will make arrangements for the services you need.

**Family Health Network Privacy Notice**

The law requires Family Health Network (FHN) to protect the privacy of your medical information. This notice explains how FHN can use or share the medical information that FHN has about you or your family. It also explains your rights.

FHN must receive and keep your medical information so you can receive your healthcare. FHN may contract with other organizations or individuals to help provide your health benefits. These contractors may also receive and keep your medical information.

In order to provide you with the right care, there are times when we will need to share your confidential information with others beyond our Health Plan. This includes for:

**Treatment.** We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our Health Plan that we are consulting with or referring you to.

**Payment.** With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes. You have a right to restrict certain disclosures of your protected health information if you pay out of pocket in full for the services provided to you.

**Healthcare Operations.** We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care and training.
Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information on your voice mail or leave an email or text message unless you tell us not to.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners. We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

Governmental Requirements. We may disclose information to a health oversight Health Plan for activities authorized by law, such as audits, investigations inspections and licensure. We are also required to share information, if requested with the U.S. Department of Health and Human Services, to determine our compliance with federal laws related to health care and to Illinois state agencies that fund our services or for coordination of your care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect the member record our Health Plan has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization. Except as described in this Notice or as required by Illinois or Federal law, we cannot release your protected health information without your written consent.

Restriction on Record. You may ask us not to use or disclose part of the clinical information. This request must be in writing. The Health Plan is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Privacy Officer, 312.880.1635.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We also will be glad to provide you information by email.
if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the Privacy Officer, 312.880.1635 and ask for the Request to Amend Health Information form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement that you disagree with us. We will then file our response and your statement, and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years, please submit your request in writing to our Privacy Officer, 312.880.1635. We will notify you of the cost involved in preparing this list.

Notification of Breach. You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of the HIPAA Privacy Rule and there is an assessment that your protected information may be compromised.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our Privacy Officer, 312.880.1635 in writing at our office further information. You also may complain to the Secretary of U.S. Department of Health and Human Services if you believe our Health Plan has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. The Health Plan reserves the right to change its Privacy Policy based on the needs of the Health Plan and changes in state and federal law.
Family Health Network does not determine your eligibility into the Waiver or Nursing Home programs. Eligibility determination is under either the Department on Aging or the Department of Human Services, Division of Rehabilitative Services. If one of these Departments has decided you are eligible, you will be asked to select a health plan. A plan will be assigned for you if you did not make a choice.

The following are some of the eligibility requirements of the Departments:

- Be a resident of the State of Illinois
- Be a citizen of the United States or a legally admitted alien
- Have a Determination of Need (DON) score of 29 points or more
- Needs will be met at a cost less than or equal to the cost of nursing services in an institutional setting
- Fully cooperate with the Medicaid application process and maintain Medicaid eligibility

If you do not meet or maintain your eligibility requirements according to the Department standards, you may be disenrolled from the waiver. Your eligibility Department will send you a notice if they have found you no longer eligible, and will give you a disenrollment date. Family Health Network will also be informed of this action and your disenrollment date.

For additional information regarding the Illinois waivers programs as alternatives to nursing homes, please visit: http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx;

Case Management Service

Family Health Network Long Term Services and Supports program is for members who have been determined to be eligible for a Home and Community Based Service (HCBS) waiver program or the Nursing Facility program. You will be assigned a Case Manager at the time you are enrolled. Your case manager will work with you, your authorized representative, or your guardian to help you determine your needs and services to meet those needs.

If you are in the Persons who are Elderly Waiver or the Persons with Disabilities Waiver, your Case Manager will visit you at least one time every 3 months. If you are in the Persons with Brain Injury Waiver, your Case Manager will contact you at least one time every month. If you are in the Persons with HIV/AIDS Waiver, your Case Manager will contact you at least monthly by phone, and visit you at least every other month.

If you live in your own home or in a Supportive Living setting, your Case Manager will complete an assessment visit and service plan with you every year. If you live in a Nursing Facility, your Case Manager will complete an assessment visit and service plan with you every 6 months. Your Case Manager can visit you more if your needs change.
At each assessment visit, your Case Manager will ask questions to learn more about you. They will ask about your strengths. They will ask what you can do and what you need help with. Your Case Manager will work with you and your authorized representative, as you decide on services to meet your needs.

If you live in a Nursing Facility, your Case Manager will approve your Long Term Care stay. Your Case Manager will work with you and your authorized representative to see if you can return to a community setting with services and supports. If you live in the community, your Case Manager will help get the services you need based on your waiver program.

You will have case management services as long as you are an Family Health Network member and in a nursing facility or HCBS Waiver program.

**Nursing Facility Service**

A Nursing Facility (NF) sometimes goes by different names such as Nursing Home, Long Term Care Facility, or Skilled Nursing Facility. A Nursing Facility is a licensed facility that provides skilled nursing or long-term care services.

These facilities have services that help both the medical and non-medical needs of residents who need assistance and support to care for themselves due to a chronic illness or disability.

They provide care for tasks like dressing, bathing, using the bathroom, meals, laundry, and other needs. In a nursing facility, the staff will take care of your medications and order refills for you.

If you live in a Nursing Facility you will need to pay a “Share of Cost” or “Patient Credit.” The Department of Human Services caseworker determines what your Patient Credit total will be based on your income and your expenses. If you have questions, your case manager will work with you to understand your Patient Credit. You will need to pay the Patient Credit to the Nursing Facility each month.

**Home and Community Based Services and Waivers**

Home and Community Based Services (HCBS) help you live in your own home or other type of community setting. Your Case Manager will work with you, your authorized representative, or guardian to find the right types of service. Not all services will be right for you. Once you agree to these services your Case Manager will work to arrange them for you.

The HCBS Waiver programs are below. The services available are next to each program. The definitions of services are listed at the end of this list. Note – These services cannot be provided to you if you have been admitted to a hospital or nursing home.

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<tr>
<th>Waiver Program</th>
<th>Services</th>
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<tr>
<td>ELDERLY WAIVER</td>
<td>Adult Day Service</td>
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<td>Also known as: AGING WAIVER or COMMUNITY CARE PROGRAM (CCP)</td>
<td>Adult Day Service Transportation</td>
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<td>Homemaker</td>
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<td>Personal Emergency Response System</td>
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<td>Waiver Program</td>
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<td>PERSONS WITH DISABILITIES WAIVER  Also known as: PHYSICAL DISABILITIES</td>
<td>Adult Day Service</td>
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<tr>
<td>WAIVER or HOME SERVICES PROGRAM (HSP)</td>
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<td>Environmental Accessibility Adaptations-Home</td>
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<td>Physical, Occupational, and Speech Therapy</td>
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<td>Specialized Medical Equipment and Supplies</td>
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<tr>
<td>PERSONS WITH BRAIN INJURY WAIVER  Also known as: BRAIN INJURY WAIVER;</td>
<td>Adult Day Service</td>
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<td>TRAUMATIC BRAIN INJURY (TBI) WAIVER; or HOME SERVICES PROGRAM (HSP)</td>
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<td>Waiver Program</td>
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<tr>
<td>PEOPLE WITH HIV OR AIDS WAIVER</td>
<td>Adult Day Service</td>
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<th>Supportive living provides an alternative to traditional nursing home care by mixing housing with personal care and supportive services, and includes these services:</th>
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<tr>
<td>Nursing Assessments</td>
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<td>Intermittent Nursing</td>
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<td>Well-being check</td>
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<tr>
<td>24 hour response/security</td>
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<tr>
<td>Meals &amp; snacks</td>
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Adaptive Equipment
This service includes devices, controls, or appliances, specified in the plan of care, which enable the member to increase his or her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Adult Day Health – Also known as Adult Day Service
This is a daytime community-based program for adults not living in Supported Living Facilities. Adult Day Service provides a variety of social, recreational, health, nutrition, and related support services in a protective setting. Transportation to and from the center and lunch are included as part of this service.

Behavioral Services
These services are behavioral therapies designed to assist members with brain injuries in managing their behavior and thinking functions, and to enhance their capacity for independent living.

Day Habilitation – Also known as Habilitation
This service provides members with brain injuries training with independent living skills, such as help with gaining, maintaining, or improving self-help, socialization, and adaptive skills. This service also helps the member to gain or maintain his or her maximum functional level.

Personal Emergency Response System
This electronic equipment allows members 24-hour access to help in an emergency. The equipment is connected to your phone line and calls the response center and/or other forms of help once the help button is pressed.

Environmental Accessibility Adaptations
These are physical modifications to a member’s home. The modifications must be necessary to support the health, welfare, and safety of the member and to enable the member to function with greater independence in their home. Without the modification a member would require some type of institutionalized living arrangement, such as nursing facility or assisted living.

Adaptations that do not help the member’s safety or independence are not included as part of this service, such as new carpeting, roof repair, central air, or home additions.

Home Delivered Meals
Prepared food brought to the member’s home that may consist of frozen meals or a heated lunch meal and a dinner meal (or both), which can be refrigerated and eaten later. This service is designed for the member who cannot prepare his or her own meals but is able to feed him/herself.
Home Health Aide
A person who works under the supervision of a medical professional, nurse, physical therapist, to assist the member with basic health services such as assistance with medication, nursing care, physical, occupational and speech therapy.

Homemaker
In-home caregiver hired through an agency. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. The caregiver can also help with hands-on personal care such as personal hygiene, bathing, grooming and feeding.

Nursing - Skilled
This service provides skilled nursing services to a member in their home for short-term acute healing needs, with the goal of restoring and maintaining a member’s maximal level of function and health. These services are provided instead of a hospitalization or a nursing facility stay. A doctor’s order is required for this service.

Nursing - Intermittent
This service focuses on long term needs rather than short-term acute healing needs, such as weekly insulin syringes or medication oversight/reminders for members unable to do this for themselves. These services are provided instead of a hospitalization or a nursing facility stay. A doctor’s order is required for this service.

Personal Assistant
In-home caregiver hired and managed by the member. The member must be able to manage different parts of being an employer such as hiring the caregiver, managing their time, submitting timesheets and completing other employee paperwork.

The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming, and feeding. Personal Assistants can include other independent direct care givers such as RNs, LPNs, and Home Health Aides.

Physical, Occupational and Speech Therapy – Also known as Rehabilitation Services
Services designed to improve and or restore a person’s functioning; includes physical therapy, occupational therapy, and/or speech therapy.

Prevocational Services
This service is for members with brain injuries and provides work experiences and training designed to assist individuals in developing skills needed for
employment in the general workforce. Services include teaching concepts such as compliance, attendance, task completion, problem-solving and safety.

**Respite**

This service provides relief for unpaid family or primary caregivers who are meeting all the needs of the member. The respite caregiver assists the member with all daily needs when the family or primary caregiver is absent. Respite can be provided by a homemaker, personal assistant, nurse or in adult day health center.

**Supported Employment**

Supported employment includes activities needed to maintain paid work by individuals receiving waiver services, including supervision and training.

**Supportive Living Program – Also known as Supportive Living Facility or Service**

An assisted living residence is a housing option that provides members with many support services to meet the member’s needs to help keep the member as independent as possible. Examples of support services to meet those needs include: housekeeping, personal care, medication oversight, shopping, meals and social programs. Supportive Living does not offer complex medical services or supports.

**Freedom of Choice**

You have the choice of nursing facility placement or home and community based services. You also have the right to choose not to receive services.

You may choose which provider/agency you want to provide your Long Term Services and Supports. A list of agencies approved by the Division of Rehabilitative Services, Healthcare and Family Services, and the Department on Aging to provide services in your service area will be reviewed with you by your Family Health Network Case Manager.

Your Family Health Network Case Manager will work with you to participate in your service plan development and in choosing types of services and providers to meet your needs. You will receive a copy of each service plan and any subsequent changes to the plan.

The services that you receive are for needs addressed on your service plan and not for the needs of other individuals in your home.

**Personal Assistant Service**

Depending on your Waiver, you may be able to select the Personal Assistant (PA) service.

If you choose to use the Personal Assistant service you are allowed to request a criminal background check on potential employees. Home Services Program will cover the cost of the background check and it will not affect your services.
You are responsible for hiring, managing and if necessary, firing your Personal Assistant.

You will receive a Member (customer) packet and a PA (employee) packet. You should keep copies of paperwork in your Member packet folder.

If you employ a PA, it is your responsibility to ensure the following:

• You need to complete and submit all necessary documentation to the local HSP office prior to the start of employment of the PA. This includes information in both the Member and PA packets.

• You need to select a PA that has the physical capability to perform the tasks under your direction, and the PA will not have a medical condition which will be aggravated by the job requirements.

• You need to provide a copy of and review your Family Health Network Service Plan with your PA so they understand your needs and hours approved.

• You will review the Time Sheet with your PA for accuracy of all information before – the Personal Assistant turns it in, and only approve hours actually worked by the PA for payment.

• Time Sheets will not be pre-signed or submitted prior to the last day worked in a billing period.

• Complete the PA’s Last Day of Employment form (in your packet) and send to the HSP office when any PA’s employment ends.

• Notify the HSP office within 24 hours of any incident resulting in injury to the PA at work.

• Complete the Report of Injury to a Provider form (in your packet) and mail or fax it to the HSP office within 24 hours after you reported it.

If you need a Personal Assistant at your place of employment or to go on vacation, you must first contact your Family Health Network Case Manager to request and obtain approval for paid services.

As a member of Family Health Network Long Term Services and Supports program you have the following rights and responsibilities.

**Your Rights**

**Non-discrimination**

You may not be discriminated against because of race, color, nation origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge, or age.
If you feel you have been discriminated against, you have the right to file a complaint with Family Health Network by calling, faxing or sending us a letter:

Phone: 888-346-4968  
Fax: 312-738-3116  
Mail: Family Health Network  
Attn: Grievance and Appeals Dept.  
322 S. Green Street, Suite 400  
Chicago, IL 60607

If you are unable to call, you may have someone call for you. If you are unable to write a letter yourself, you may have someone write it for you.

**Confidentiality**

All information about you and your case is confidential, and may be used only for purposes directly related to treatment, payment, and operation of the program including:

- Establishing your initial and continuing eligibility
- Establishing the extent of your assets, your income, and the determination of your service needs
- Finding and making needed services and resources available to you
- Assuring your health and safety

No information about you can be used for any other purpose, unless you have signed a Release of Information form.

**Transfer to other Provider/Agency**

You may request to transfer from one provider to another. If you want to transfer, you should contact your Family Health Network Case Manager to help arrange the transfer.

**Temporary Change in Residence**

If you will be temporarily residing in another location in Illinois and want to continue to receive services, contact your Family Health Network Case Manager. Your Case Manager will assist you by arranging service transfer to your temporary location.

**Service Plan (does not apply to SLP)**

Your Service Plan establishes the type of service, the number of hours of service, how often the service will be provided, and the dates the services are approved. Your Provider cannot change your Service Plan. If you need a change in services you need to call your Family Health Network Case Manager to review your needs and make changes to your Service Plan.
If you want more services than your Service Plan allows, you may request your provider to provide more services than are listed on your Service Plan, but you may be required to pay 100% of the cost of those additional services.

Quality of Service

If you do not believe your provider/caregiver is following your Service Plan, or if your caregiver does not come to your home as scheduled, or if your caregiver is always late, you should call the caregiver agency and talk to your caregiver’s supervisor. If the problem is not resolved you should call your Family Health Network Case Manager. If the problem is still not resolved you should call Family Health Network at 888-346-4968 to file a grievance.

Your Responsibilities

Non-Discrimination of Caregivers

You must not discriminate against your caregivers because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge or age. To do so is a Federal offense.

Reporting Changes

When you become enrolled in the Long Term Services and Supports program, you must report changes to your information including:

<table>
<thead>
<tr>
<th>Change</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to your services or service needs</td>
<td>Family Health Network Case Manager</td>
</tr>
<tr>
<td>Change of address or phone number</td>
<td>Family Health Network Case Manager</td>
</tr>
<tr>
<td>Even if temporary</td>
<td>Enrollment Agency</td>
</tr>
</tbody>
</table>

Financial Benefits

Your Long Term Services and Supports program is paid by Medicaid, a Federal and State funded program monitored by Illinois Department of Healthcare and Family Services (HFS). Federal law allows HFS to recover the Medicaid assistance paid out for Long Term Services and Supports through what is known as “Medicaid Estate Recovery”. In order to recover the Medicaid assistance paid out for your LTSS services, HFS can file a claim against your estate, which includes real and personal property.

If you are married, HFS cannot seek to recover its claim against your estate until after your spouse is deceased. Your spouse will be allowed to keep your home and other real and personal property until his/her death. HFS can seek to recover money from your estate equal to the amount of Medicaid assistance paid out for your LTSS services. For further information ask your Family Health Network Case Manager.
Hospital or Nursing Home Admission

If you are entering a hospital, nursing home, or other facility for any reason, you or your authorized representative should inform your Family Health Network Case Manager before or as soon as possible after you have entered such a facility. Your services cannot be provided while you are in these facilities, but can be provided as soon as you return home. Inform your Family Health Network Case Manager when you will be discharged home, so we can check on your service needs.

If you are admitted in a hospital or facility for more than 60 calendar days, the enrollment in your home and community waiver may be terminated. (For Supportive Living Program, discharge from the waiver is automatic on the day of admission to a nursing home). If you are interested in returning home and need services, contact your Family Health Network Case Manager to assist you in reestablishing your in-home services and requesting reapplication to the home and community waiver.

Absent from Home

LTSS Services cannot be provided if you are not at home. If you are away from your home for any reason for over 60 calendar days, your case will be referred to your Enrollment Agency for possible termination from the waiver program.

You must inform your caregiver/provider if you plan to be absent from your home when your scheduled services are to be provided, such as for a doctor’s appointment, a general outing, or a short vacation. Notify your caregiver/provider when you will not be home and when you plan to return so they can resume services upon your return. During your absence, give your Family Health Network Case Manager your temporary phone number and address, in case you need to be reached.

You must Cooperate in the Delivery of Services

To assist your caregivers you must:

• Notify your caregiver/provider at least 1 day in advance if you will be away from home on the day you are to receive service.

• Allow the authorized caregiver into your home.

• Allow the caregiver to provide the services authorized on your Service Plan you approved.

• Do not require the caregiver to do more or less than what is on your Service Plan. If you want to change your Service Plan call your Family Health Network Case Manager. Your caregiver cannot change your Service Plan, except for SLP.

• You and others in your home must not harm or threaten to harm the caregiver or display any weapons.

Not cooperating as noted above may result in the suspension or termination of your LTSS services. Your [Insert Plan Name] Case Manager will work with you
and the caregiver to develop a Care Management agreement to restart your services.

**Reporting Abuse, Neglect, Exploitation, or Unusual Incidents**

The Health Care Worker Background Check Act applies to all unlicensed individuals employed or retained by a health care employer as home health care aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel, or an individual working in any similar health-related occupation where he or she provides direct care. You can contact the Department of Public Health online or by phone at 217-785-5133 to verify status prior to employment, or the Department of Financial and Professional Regulation for information on any Licensed Practical Nurse (LPN) or Registered Nurse (RN) (nurses) that you want to employ to see if they have allegations of abuse, neglect or theft.

If you are the victim of abuse, neglect or exploitation, you should report this to your Family Health Network Case Manager right away. You should also report the issue to one of the following agencies based on your age or placement. All reports to these agencies are kept confidential and anonymous reports are accepted.

- **Nursing Home Hotline 1-800-252-4343**
  
  Illinois Department of Public Health Nursing Home Hotline is for reporting complaints regarding hospitals, nursing facilities, and home health agencies and the care or lack of care of the patients.

- **Supportive Living Program Complaint Hotline 1-800-226-0768**

- **Adult Protective Services 1-866-800-1409 (TTY – 1-888-206-1327)**

  The Illinois Department on Aging Adult Protective Services Hotline is to report allegations of abuse, neglect, or exploitation for all adults 18 years old and over. Your Family Health Network Case Manager will provide you with 2 brochures on reporting Abuse, Neglect and Exploitation. You can request new copies of these brochures at any time.

Illinois law defines abuse, neglect, and exploitation as:

- **Physical abuse** — Inflicting physical pain or injury upon a senior or person with disabilities.

- **Sexual abuse** — Touching, fondling, intercourse, or any other sexual activity with a senior or person with disabilities, when the person is unable to understand, unwilling to consent, threatened or physically forced.

- **Emotional abuse** — Verbal assaults, threats of abuse, harassment, or intimidation.

- **Confinement** — Restraining or isolating the person, other than for medical reasons.
• **Passive neglect** — The caregiver’s failure to provide a senior or person with disabilities with life’s necessities, including, but not limited to, food, clothing, shelter or medical care.

• **Willful deprivation** — Willfully denying a senior or person with disabilities medication, medical care, shelter, food, a therapeutic device or other physical assistance, and thereby exposing that adult to the risk of physical, mental, or emotional harm — except when the person has expressed intent to forego such care.

• **Financial exploitation** — The misuse or withholding of a senior or person with disabilities’ resources to the disadvantage of the person or the profit or advantage of someone else.

**Grievances and Appeals**

For information on Grievances and Appeals, please look at that section of your Member Handbook.