This handbook will tell you how to use your Healthfirst plan. Keep this handbook where you can find it when you need it.
Senior Health Partners
Member Services

If you need help, you can call, or write to us at the address below.

Senior Health Partners
100 Church Street, 17th Floor
New York, NY 10007
1-800-633-9717

Call if you need to talk to your Care Team, ask about benefits, get referrals, replace your Member ID card, change or pick a provider.

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, “Healthfirst”). Coverage for Senior Health Partners, Managed Long-Term Care Plan, is provided by Healthfirst PHSP, Inc. Plans contain exclusions and limitations.

The State of New York has created a Participant Ombudsman Program called the Independent Consumer Advocacy Network (ICAN) to provide Participants/Members free, confidential assistance on any services offered by Healthfirst Health Plan, Inc. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Special services are available for people with special needs. If you have special needs, call us and we will help you find services (and providers) that will fit your needs. We also can provide materials in large print if you ask us. We can help you get VCO (Voice Carry-Over) or TTY (Text Telephone Device) by dialing 1-888-542-3821 (English); 1-888-867-4132 (Spanish) to help make communication easier. This member handbook is also available in large print/CD if you ask us.
# Important Senior Health Partners Phone Numbers

<table>
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<tr>
<th>IMPORTANT SENIOR HEALTH PARTNERS PHONE NUMBERS</th>
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<tbody>
<tr>
<td>Care Team</td>
<td>1-800-633-9717</td>
</tr>
<tr>
<td>Quality Management Department</td>
<td>1-800-633-9717</td>
</tr>
<tr>
<td>Enrollment Unit</td>
<td>1-866-585-9280</td>
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<tr>
<td>Transportation</td>
<td>1-866-202-3874</td>
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<tr>
<th>OTHER IMPORTANT PHONE NUMBERS</th>
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<tbody>
<tr>
<td>Independent Consumer Advocacy Network (ICAN)</td>
<td>1-844-614-8800</td>
</tr>
<tr>
<td>New York Medicaid Choice</td>
<td>1-888-401-6582</td>
</tr>
<tr>
<td>New York State Department of Health</td>
<td>1-866-712-7197</td>
</tr>
<tr>
<td>NYC Human Resources Administration</td>
<td>1-718-557-1399</td>
</tr>
<tr>
<td>Nassau ‘NY Connects</td>
<td>1-516-227-8900</td>
</tr>
<tr>
<td>Westchester Local Dept. Social Services</td>
<td>'1-914-995-5000</td>
</tr>
</tbody>
</table>

*General Information for City Offices number
## Important Names and Phone Numbers

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number/Address</th>
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<tr>
<td>Care Manager</td>
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**Names, Addresses, and Phone Numbers of Providers**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number/Address</th>
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**Your Senior Health Partners Office Address**

<table>
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<th>Name</th>
<th>Phone Number/Address</th>
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**In an emergency, call 911 immediately.**
Call Senior Health Partners within 24 hours.
About this Member Handbook

This handbook is given to you to help you learn about the plan. Please read it and use it when you need information about how the plan works. For example:

- When you want to know what services are covered and how to get them.
- What to do in an emergency.
- What to do when you are unhappy with services.
- When you need to make decisions about your healthcare.

If you enroll in Senior Health Partners, this handbook is your guide to services and your contract (along with your enrollment agreement). If you lose the directory, you can ask for one by calling 1-800-633-9717 (TTY 1-888-542-3821 for English; 1-888-867-4132 for Spanish), 24 hours a day, 7 days a week. You will get the participating Provider Directory in the mail.

To be a Senior Health Partners member, you have to be eligible for Medicaid or be able to pay for services yourself (this is called private pay). If you pay yourself, read the Private Pay section at the end of this handbook.

Membership Card

Your Senior Health Partners identification card (Member ID card) will be mailed to you. Carry this card with you at all times. You need to show it to your provider.

Tips for New Members

- Keep your handbook within easy reach.
- Keep your Member ID card in your wallet with your Medicaid and Medicare cards.
- Make sure you have the Senior Health Partners telephone numbers near your telephone.
- To help you work with your personal care aide, we included a guide in your welcome kit. It gives you examples of what your aide can and cannot do. It also gives you a place to write down information about your home care routine.
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1 Medicaid Member Handbook
Welcome to Senior Health Partners

Thank you for choosing Senior Health Partners for your managed long-term care. We want to be sure you get off to a good start as a new member. This handbook will help you understand your health benefits.

Senior Health Partners is a Healthfirst plan. Healthfirst is New York’s largest not-for-profit health insurer. We have been offering affordable plans to New Yorkers for more than 25 years.

As a Senior Health Partners member, you will get services from providers who are in-network. The plan and your providers will help you stay in your home for as long as possible.

What is Managed Long-Term Care?

The goal of managed long-term care is to help you stay in your home or community as long as possible. It gives you the care and support you need, so you can handle daily activities that you cannot do without help. It gives you helpful medical, personal, and social services you may need. You will be assigned a Care Team that will get to know you. The team will help you find providers in your area, and services and supports to help you meet your needs.

A home health aide or personal care aide may be assigned to help you with activities of daily living (ADL) when you can no longer do these things for yourself. These are things like:

- eating
- going to the bathroom
- getting out of bed
- bathing
- dressing

Our goal is to help you stay as independent as possible.

Your Rights and Responsibilities as a Senior Health Partners Member

As a Senior Health Partners Member, You Have the Right to:

- receive medically necessary care.
- receive care and services at the time you need them.
- ask for an increase in your services, including, but not limited to, your home care services.
- privacy about your medical records.
- receive information on available treatment options and alternatives, given to you in a specific way (if you ask for it) and in a language you understand.
- receive oral translation services free of charge to get information in a language you understand.
- receive all information you need to give us approval before the start of any treatment.
- receive a copy of your medical records and ask that the records be changed or corrected.
- make decisions about your healthcare, including the right to refuse treatment.
- to be treated with respect and due consideration for your dignity.
- receive a copy of the annual disenrollment rights.
- be told where, when, and how to get the services you need from your managed long-term care plan (this includes how you can get covered benefits from out-of-network providers if they are not available in the plan network).
- complain to the New York State Department of Health or your Local Department of Social Services; and the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
receive help from the Independent Consumer Advocacy Network (ICAN) (also known as a Participant Ombudsman program).

name someone to speak for you about your healthcare and treatment.

give instructions about what is to be done if you are not able to make medical decisions for yourself.

participate in the six-month assessment visit or sooner as needed

review your care needs with your care team during the monthly call

**Your Right to Use an Advance Directive**

If you are unable to make healthcare decisions for yourself (due to an accident, serious illness, or other issue), you have the right to say what you want to happen. This means you can:

- fill out a written form to give someone the legal authority to make medical decisions for you.
- give your providers written instructions about how you want them to handle your medical care.

The legal documents that you can use to give your directions in advance of these situations are called “advance directives.” There are different types and different names for them. Documents called “healthcare proxy form,” and “power of attorney for healthcare” are examples of advance directives.

If you want to use an “advance directive” (to give instructions about your care), here is what to do.

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, a social worker, or from an office supply store. You can also call Healthfirst Member Services to get the forms (phone numbers are printed on the back of this booklet).

- **Fill it out and sign it.** Before you fill it out, think about having a lawyer help you. This is a legal document about your healthcare services. Be sure to sign it when you are done.

- **Give copies to the right people.** You should give a copy to your provider and to the person who will make decisions for you if you can’t. You may want to give copies to close friends or family members. Be sure to keep a copy for yourself and put it in a safe place.

If you know that you are going to be hospitalized, and you have signed an advance directive, bring a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you if you have a signed advance directive form and if you have it with you.

- If you do not have a signed advance directive form, the hospital has forms available. You can fill one out, and also sign it there if you want to.

It is your choice if you want to fill out an advance directive (including if you want to sign one if you are in the hospital). As stated by the law, no one can deny you care or discriminate against you if you have or don’t have a signed advance directive.

What if your instructions are not followed?

If you have a signed advance directive, and you believe that a provider or hospital did not follow the instructions on it, you can call or write to file a complaint with The New York State Department of Health.

New York State Department of Health
Division of Long Term Care
One Commerce Plaza, Room 1620
Albany, New York 12210
1-866-712-7197

At Senior Health Partners, we must obey New York State Law on advanced directives. Our team knows the law, and educates the community. We will keep your advance directive information as part of your records. By law, you must write down your healthcare wishes (if you can’t make a decision for yourself), sign an advance directive form, and have an adult witness it. You can change your mind about your healthcare proxy (this is the person you assign to make healthcare decisions for you) or your advance directives at any time. Just fill out new forms, sign them, and have them witnessed.
Responsibilities of Members

To get the greatest benefit from enrollment in Senior Health Partners, you have these responsibilities:

1. Participate in Making Your Healthcare Decisions by:
   - talking openly and honestly with your provider and Care Team about your care.
   - asking questions to be sure you understand your Person Centered Service Plan (PCSP) and knowing what will happen if you do not follow your PCSP. Your PCSP and changes to your PCSP will be discussed and documented as part of our monthly care management call.
   - partnering in care decisions and being in charge of your own health.
   - completing self-care as planned.
   - keeping appointments or telling the Care Team if you need to change an appointment.
   - using the Senior Health Partners network providers for care (except in emergency situations).
   - telling Senior Health Partners that you got healthcare services from other healthcare providers.
   - helping us with policy development by writing to us, calling us, or being part of the member advisory council.
   - reading and signing the “Consumer/Designated Representative Acknowledgement of the Roles and Responsibilities for Receiving CDPAS” document (when you get it).

2. Support Senior Health Partners by:
   - giving us your opinions, concerns, and suggestions through your Care Team, or through the Senior Health Partners Grievance and Appeals Process.
   - reading the handbook and following procedures to get healthcare services.
   - respecting the rights and safety of all those involved in your care and helping Senior Health Partners to make your home safe.
   - telling your Care Team any of these:
     - if you are leaving the service area
     - if you have moved or have a new telephone number
     - if you have changed providers
     - any changes in condition that may affect our ability to give you care

Notice of Information Available on Request

The below is available to you if you ask for it:

- a list of names, business addresses, and official positions of the members of Healthfirst’s Board of Directors, officers, controlling partners, and owners or partners
- a copy of the most recent annual certified financial statement of Healthfirst, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant
- information related to member complaints and aggregated information about grievances and appeals
- Senior Health Partners’ procedures for protecting confidentiality of medical records and other member information
- a written description of the organizational arrangement and ongoing procedures of Senior Health Partners’ Quality Assurance Program
- a description of the procedures followed by Senior Health Partners in making decisions about the experimental or investigational nature of individual drugs, medical devices, or treatments in clinical trials
- Upon written request, specific clinical information relating to a certain condition or disease, or other clinical information which Senior Health partners might consider in its utilization review, and how it is used in the utilization review process. However, when information is specific to Senior Health Partners, the member/future member will only use it to help the member/future member
check the covered services given by Senior Health Partners.

- individual health practitioner affiliations with participating hospitals and other facilities
- licensure, certification, and accreditation status of participating providers
- written application, procedures, and minimum qualification requirements for healthcare providers to be considered by Senior Health Partners
- information concerning the education, facility affiliation, and participation in clinical performance reviews made by the Department of Health, of healthcare professionals who are licensed, registered, or certified under Article 8 of the State Education Law

Advantages of Enrolling in Senior Health Partners

The decision to join Senior Health Partners is important. It affects how you get the healthcare services you need on a regular basis. As a member, you will have a Care Team. You will be assigned a Care Manager who knows how to care for people with long-term-care needs. This person will help you learn what services are available to you and how to use your Medicaid benefits.

If you choose Senior Health Partners, you agree to get services only from Senior Health Partners and its network of providers, as described in your Person Centered Service Plan (PCSP).

Some benefits to being a member:

- You get a personal Care Team who will get to know you personally.
- Your Care Team will manage your care at home, in a hospital, or in a nursing home.
- Your family and home caregivers will help you stay in your own home.
- You are enrolled until you decide to disenroll.
- You can get help with Medicaid recertification.

Eligibility

You may be eligible to enroll in Senior Health Partners if you are:

- 18 years old.
- live in Manhattan, Bronx, Brooklyn, Queens, Staten Island, Nassau, or Westchester County.
- qualified for Medicaid or agree to pay a private pay premium for care (as described in Enrollment, and Private Pay Section). Private Pay does not apply to Staten Island, or to Nassau or Westchester County.
- eligible for nursing home level of care (as of the time of enrollment) for 18–20 years old and qualify for Medicare and Medicaid, or 18 years old or more and only eligible for Medicaid.

A. need community-based long-term care services (CBLTCS)* covered by Senior Health Partners for a continuous period of more than 120 (one hundred twenty) days from the date of enrollment.

B. You must need at least one of the services below.

- nursing services in the home
- therapies in the home
- home health aide services
- personal care services in the home
- Adult Day Health Care
- private duty nursing
- Consumer Directed Personal Assistance Services (CDPAS)

*CBLTCS are healthcare and supportive services for people of all ages with functional limitations or chronic illnesses. These services are help with daily activities such as bathing, dressing, preparing meals, and taking medications. CBLTCS will give members Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Programs, and Personal Care Services.

If you qualify for Senior Health Partners, you must sign an Enrollment Agreement Attestation and agree to follow the rules of Senior Health Partners.

Enrollment is subject to approval by New York Medicaid Choice (NYMC) or LDSS or place chosen by the New York State Department of Health, except for private pay. See Private Pay Section.
Conditions for Denial of Enrollment

You will be denied enrollment if any of these apply:

- You did not meet one of the eligibility requirements.
- You were previously a member of Senior Health Partners and do not meet our requirements for re-enrollment. See Re-enrollment Provisions Section.
- Senior Health Partners has reached the most number of private pay members that may be enrolled (according to New York State).

Following a Conflict-Free Evaluation and Enrollment Center (CFEEC) evaluation (see next section), you will get a notice about your eligibility for CBLTCS. If you are not eligible, you will get a notice saying you can have a Fair Hearing (except for private pay members) to talk about eligibility. See Private Pay Section.

Enrollment and Effective Dates of Coverage

Conflict-Free Evaluation and Enrollment Center (CFEEC)

The CFEEC is an entity, New York Medicaid Choice (NYMC), that contracts with New York State Department of Health (NYSDOH) to provide initial evaluations of applicants to determine eligibility for community-based long-term care services. They help educate new applicants. This evaluation is not required for applicants transferring from one MLTC plan to another except for non-dual applicants coming from Medicaid Managed Care. All applicants that are new to community-based long-term care services or have not had community-based long-term care services for more than 45 (forty-five) days must have a CFEEC evaluation and can call the CFEEC at 1-855-222-8350, Monday to Friday, 8:30am–8pm, or Saturday, 10am–6pm, to schedule an appointment.

Once New York Medicaid Choice decides if a person is eligible for CBLTCS (for a continuous period of more than 120 [one hundred twenty] days), the person can choose an MLTC plan. The CFEEC review is only good for 75 (seventy-five) days. After this, a new evaluation has to be done if the person does not pick a plan and still wants CBLTCS.

Enrolling in Senior Health Partners is voluntary. If you want to join, you (or someone on your behalf) can call Senior Health Partners. Our team will help you contact New York Medicaid Choice to find out more about Senior Health Partners. If you qualify and have a completed New York Medicaid Choice review (if required), a Healthfirst employee will check your Medicaid eligibility. We will give you a call to provide you with more information about the plan and will schedule a visit for one of our registered nurses to come to your home to assess your clinical eligibility for the plan. We will also ask you for information about your healthcare needs.

- Your Medicaid eligibility must be reviewed and approved by the NYC Human Resources Administration or Local Department of Social Services.
- If you do not currently have Medicaid, we will help you apply for Medicaid coverage (unless you are a private pay member).

If you are not eligible for Medicaid, you can still join Senior Health Partners. But, you must pay privately, and Senior Health Partners may not be over its enrollment limit (for private pay enrollees). If you want to pay privately, see Private Pay Section.

Our Clinical Eligibility Nurse will come to your home to get some information about you.

- Our Clinical Eligibility Nurse will ask you to sign an authorization form to let him/her check your healthcare needs and clinical eligibility.
  - Our nurse will ask you to sign a form that lets your healthcare providers give us your medical information.
  - Our nurse will also review this handbook with you.

- Our Clinical Eligibility Nurse will visit you in your home within 30 (thirty) days after you ask to join Senior Health Partners, or from CFEEC’s referral, to:
  - identify your healthcare needs (also called an “initial assessment”).
  - find out if you are eligible for nursing home
level of care, as required for enrollment (if you have Medicaid only or have Medicare and Medicaid and are age 18 – 20).

➤ find out if you require community-based long-term care services offered by Senior Health Partners for a continuous period of more than **120 (one hundred twenty) days**.

➤ give you information and a Health Care Proxy form (if you want to assign someone you trust to make healthcare decisions for you).

➤ talk about services you may need.

After the initial assessment, our nurse will ask you to sign the Enrollment Agreement Transfer Attestation. Private pay enrollees will sign an Enrollment Agreement for Private Pay Participants. See Private Pay Section. By signing the Enrollment Agreement Transfer Attestation, you agree to:

➤ get all covered services from Senior Health Partners and our network providers.

➤ participate in Senior Health Partners according to the terms and conditions described in this handbook.

Before your enrollment date, we may contact you to answer questions or get more information. You should respond as soon as you can, so you can get enrolled as soon as possible. After this, you will get your membership letter and a Senior Health Partners Member ID card.

Your enrollment effective date will start on the first of the month following the successful completion of your application. After this, your Care Team will call you to discuss your first PCSP and answer any questions you have. Your Care Team will also ask you, your provider, and your family/caregivers to help with any future changes in your PCSP.

Withdrawal of Enrollment

You can ask Senior Health Partners verbally or in writing to withdraw your application or enrollment agreement by noon (12pm) on the 20th day of the month before your enrollment date.

If your request is received after this, you will be disenrolled from Senior Health Partners on the first of the next month. You may also contact New York State Medicaid Choice directly to withdraw your application or enrollment agreement.

Getting Care/Care Management

The Senior Health Partners Care Team

After you enroll, you will be assigned a Primary Care Manager (PCM). Your PCM is supported by specialty teams. This team will manage your chronic health problems.

With the help of specialty teams, your Care Team will check changes in your health, and coordinate care and services. The team can help you with any health issues you have. You can ask to change any member of your Care Team at any time.

Your Care Team will develop a Person Centered Service Plan (PCSP) (with you and any one you want to help you with your plan of care, including your providers) to meet your healthcare needs. The PCSP will include your goals, objectives, and special needs. Your Care Team will contact your provider to talk about and develop your PCSP. This plan will change as your needs change. It will be re-evaluated at least every **six (6) months**. See Care Planning and Care Management Section.

Your Care Team will work with you and your provider to arrange appointments and transportation, and talk to other care providers about services covered (and not covered) by Senior Health Partners. Your Care Team will conduct an assessment of your home during the evaluation, to make it more functional to support activities for daily living. By helping you manage all parts of your care, your Care Team can find problems early, stop problems from getting worse, and help you avoid trips to the hospital and emergency room.

Access to Care

Before you can get most covered services, your Care Team must authorize the service. Some covered services require a provider’s order. However, your provider or your Care Team does not have to authorize services for you in an emergency or urgent situation.
You can also go to the podiatrist, dentist, audiologist, and optometrist for tests and routine services without prior authorization. See Benefits and Coverage Section.

**Where You Will Get Services**

Most of your covered healthcare services are given in your home or can be handled in the community within our provider network. You can use services in a medical office for dental, podiatry, audiology, or optometry services. You may get inpatient nursing home services in one of our participating inpatient nursing home facilities.

**Primary Care Providers and Other Non-Covered Service Providers**

You can choose your own provider, as described in this handbook. You can also change your provider at any time.

If you do not have a provider, your Care Team can help you find a provider.

If you need help finding or changing your provider, call a member of your Care Team at the telephone number on your Member ID card. You can choose any provider you want for services not covered by Senior Health Partners. Your Care Team will help you find providers for non-covered services if you do not have a provider. See Non-Covered Services Section.

**Participating Providers and Covered Services**

You can choose providers for covered services paid for by Medicare. Senior Health Partners pays the Medicare copays for covered services if Medicare is the primary payer. However, when Medicare stops paying for these services, you must use a network provider in order for Senior Health Partners to cover the service. So it may be better for you to choose one of our network providers right from the start.

When you enroll, you will get a Provider Directory. You can choose any network provider from this list for covered services. Senior Health Partners will help you choose or change a provider for covered or non-covered services.

You can switch to another network provider at any time. The provider will be changed as soon as possible. If you have questions about the qualifications of any provider, you can ask your Care Team.

Network providers will be paid in full directly by Senior Health Partners for each service approved and given to you, with no copay or cost to you. You must pay the Medicaid Spend Down/Surplus, if you have one, to keep your Medicaid benefit. See Monthly Spend Down/Surplus Section.

**NOTE:** Medicaid Spend Down/Surplus does not apply to private pay members.

If you get a bill for covered services approved by Senior Health Partners, please call your Care Team. You may have to pay for services that were not approved by Senior Health Partners. You may pay for covered services that were given by out-of-network providers and without prior authorization.
Benefits and Coverage/Coordination of Other Medical Services

The benefits listed below are fully covered in your Person Centered Service Plan (PCSP).

Senior Health Partners Covered Services:

**PRIOR AUTHORIZATION IS REQUIRED**

<table>
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<tr>
<th>Covered Services</th>
<th>Definition</th>
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<tr>
<td>Adult Day Health Care</td>
<td>Care and services given in a healthcare facility, which includes: medical, nursing, nutrition, social services, rehabilitation therapy, leisure time activities, dental, or other services.</td>
</tr>
<tr>
<td>Audiology and Hearing Aids</td>
<td>Audiology services include examination, testing, hearing aid evaluation, and prescription. Hearing aid services include selecting, fitting, repairs, replacements, special fittings, and batteries.</td>
</tr>
<tr>
<td>Care Management</td>
<td>Care Management helps coordinate services that you find in the Person Centered Service Plan (PCSP). Care Management services include referral, help in or management of services to get medical, social, educational, psychosocial, financial, and other services in support of the PCSP, regardless if services are in the Benefit Package.</td>
</tr>
<tr>
<td>Consumer Directed Personal Assistance Service (CDPAS)</td>
<td>Lets you (or the person acting on your behalf) be responsible for hiring, training, supervising, arranging back-up coverage when needed, keeping payroll records, and if needed, terminating the employment of the person giving personal care services (see section “Consumer Directed Personal Assistance Service (CDPAS)”).</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Includes, but is not limited to, routine exams, preventive, and therapeutic dental care, dental implants, dentures, and supplies.</td>
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## Covered Services

<table>
<thead>
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<th>Durable Medical Equipment (DME)</th>
<th>Definition</th>
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<tr>
<td>Medical/Surgical Supplies: Items for medical use (other than drugs) that treat a specific medical condition such as diabetes, wound dressings, and other prescribed therapeutic supplies.</td>
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<tr>
<td>Medical Equipment: Adaptive devices and equipment prescribed by a medical provider.</td>
<td></td>
</tr>
<tr>
<td>Enteral and Parenteral Nutritional Supplements: Liquid nutritional supplements as prescribed. Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism.</td>
<td></td>
</tr>
<tr>
<td>Prosthetics: Artificial substitute or replacement of a limb.</td>
<td></td>
</tr>
<tr>
<td>Orthotics: Appliances and devices used to support or correct a movable part of the body.</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Footwear: Shoes, shoe modifications, or shoe additions that are used to correct, help, or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace.</td>
<td></td>
</tr>
</tbody>
</table>

**Home Care**

| Home Health Aide: Home Health Aide services may include vital signs, giving pre-drawn insulin, effortless motion exercises, housekeeping services. |
| Home Care |
| Physical Therapy (PT): Exercise and physical activities used to work muscles and improve activity levels. A licensed physical therapist must follow the PT rules in your plan of care. |
| Occupational Therapy (OT): Therapy using specific daily living activities to help people with physical or mental limitations. A licensed physical therapist must follow the OT rules in your plan of care. |
| Speech Pathology (SP): Therapeutic treatment of speech impairments (such as lisping and stuttering) or speech difficulties that result from illness. A licensed speech language pathologist must follow the SP rules in your plan of care. |
| Medical Social Services: Help with getting and keeping benefits, so you can stay in the community. |

**Home Delivered or Congregate Meals**

| Meals given to you at home or in another setting (for example, an adult home) if you do not have cooking equipment or if you have a special need. |

**Non-emergent Medical Transportation**

<p>| Travel by ambulance, ambulette, taxi, or livery service to medical care and services or public transportation at the appropriate level for your condition in order to obtain necessary medical care and services. |</p>
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home Care/Long Term Placement (Permanent Placement)</td>
<td>Care by an in-network licensed facility (see “Nursing Home Care/Long Term Placement (Permanent Placement)” section).</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Provided by the Senior Health Partners Registered Dietician (RD) or Diet Technician (DT). The RD or DT work with you and the care team on your diet.</td>
</tr>
<tr>
<td>Optometry/Eyeglasses</td>
<td>Includes the services of an optometrist and an ophthalmic dispenser, eyeglasses, medically necessary contact lenses, and other low-vision aids. Eye exams are also covered to detect visual defects and eye disease. Exams that include refraction are limited to every two (2) years unless medically necessary. Routine vision services do not require authorization. Medically necessary services may require prior authorization.</td>
</tr>
</tbody>
</table>
| Outpatient Rehabilitation Therapies                 | Physical Therapy (PT): Rehabilitative health that uses specific exercises and equipment to help patients get back or improve their physical abilities.  

Occupational Therapy (OT)*: Rehabilitative health that uses specific exercises and equipment to help patients get back or improve their abilities to perform daily activities of living.  

Speech Pathology (SP)*: Rehabilitation services to get back your functional level of speech or language.  

*SP and OT will be limited to 20 (twenty) visits per calendar year, and PT will be limited to 40 (forty) visits per calendar year. Limits do not apply to members under age 12, members who are developmentally disabled, and members with a traumatic brain injury. Senior Health Partners may authorize more visits. |
<p>| Personal Care                                        | Help with one or more activities of daily living, such as walking, cooking, cleaning, bathing, using the bathroom, personal hygiene, dressing, feeding, nutritional and environment support function tasks. |
| Personal Emergency Response System                   | An electronic device that sends a signal to a medical response center when you are having a physical, emotional, or environmental emergency.                                                                 |
| Podiatry                                             | Routine foot care to help with localized illness, injury, or symptoms involving the foot; or for medical care, such as diabetes, ulcers, and infections. Routine hygienic care is not covered unless there is a medical condition. |
| Private Duty Nursing                                 | Private duty nursing services are medically necessary services given to you at your permanent or temporary home by licensed registered professional or licensed practical nurses (RNs or LPNs) that follow provider orders. The services may be ongoing and may go above the line of care from certified home healthcare agencies (CHHAs). |</p>
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Therapy</td>
<td>Delivery of preventive, maintenance, and rehabilitative airway-related techniques and procedures, including oxygen and other inhalation therapies prescribed by a provider and given by a qualified company/respiratory therapist.</td>
</tr>
<tr>
<td>Social Day Care</td>
<td>A program that gives members who have limited functions with socialization, supervision and monitoring, and nutrition. Care is given in a safe setting during any part of the day, but for less than a 24-hour period. Other services may include, but are not limited to, personal care help, teaching daily living skills, transportation, caregiver help, and case help.</td>
</tr>
<tr>
<td>Social and Environmental Supports</td>
<td>Services and items include, but are not limited to, home maintenance tasks, homemaker/care services, housing improvement, and respite care.</td>
</tr>
<tr>
<td>Telehealth Services</td>
<td>Electronic information and communication technologies to deliver healthcare services like assessment, diagnosis, consultation, treatment, education, care management, and/or self-management.</td>
</tr>
</tbody>
</table>

The services below are not covered by Senior Health Partners. They are covered by Medicaid and/or Medicare.

Non-Covered Services:¹

<table>
<thead>
<tr>
<th>Non-Covered Services</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Care Services</td>
<td>A hospital (or other institutional bed) to get care, including room, board, and general nursing.</td>
</tr>
<tr>
<td>Outpatient Hospital Care Services</td>
<td>Care that you get in a clinic, medical office, or other place that does not have a “regular” hospital bed.</td>
</tr>
<tr>
<td>Provider Services</td>
<td>Preventive care, primary medical care, and specialty services given to you by a provider. This includes nurse practitioners and provider assistants who work with the provider. Provider services can include services given in an office setting, a clinic, a facility, or in the home.²</td>
</tr>
<tr>
<td>Alcohol and Substance Abuse Services</td>
<td>Treatment to end too much use of bad substances such as alcohol or drugs.</td>
</tr>
<tr>
<td>Chronic Renal Dialysis</td>
<td>Process used to treat advanced and permanent kidney failure at a renal dialysis center.</td>
</tr>
<tr>
<td>Emergency Transportation</td>
<td>Transportation by ambulance when you have an emergency.</td>
</tr>
</tbody>
</table>

Family Planning Services | Contraceptive and birth control services.
### Non-Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Services</td>
<td>Full care for people who are terminally ill (a medical issue that leads to death). Services include pain management, counseling, respite care, prescription drugs, inpatient care and outpatient care, and services for the person’s family. If you need and are eligible for hospice services while still a member, you can get hospice without disenrolling from Senior Health Partners. Hospice services are not included in the plan benefit and are billable directly to Medicare and Medicaid. However, if you are a resident of a skilled nursing facility (SNF) and you enroll in hospice while in the SNF, Senior Health Partners will pay for the room and board portion of your SNF stay.</td>
</tr>
<tr>
<td>Laboratory and Radioisotope Services</td>
<td>Tests and procedures ordered by a qualified medical professional.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Medical specialty that helps with the prevention, diagnosis, and treatment of mental illness.</td>
</tr>
<tr>
<td>Prescription and Non-Prescription Drugs, Compounded Prescriptions</td>
<td>Medications prescribed and/or recommended by a provider. Prescriptions prepared by a pharmacist.</td>
</tr>
<tr>
<td>Office for People with Developmental Disabilities (OPWDD) Services</td>
<td>Long-term therapy services given by treatment facilities certified by OPWDD; comprehensive Medicaid Case Management services; and home and community based waiver program services for the developmentally disabled.</td>
</tr>
<tr>
<td>Rural Health Clinic Services</td>
<td>Federally Qualified Health Centers (FQHCs) that have affordable, quality, primary care services.</td>
</tr>
<tr>
<td>All Other Services Listed in the Title XIX State Plan</td>
<td>Services paid for by Medicaid Fee-for-Service.</td>
</tr>
</tbody>
</table>

### Benefits cannot be transferred from you to any other person or organization.

1) Non-covered services will be paid for by Medicare, Medicaid Fee-for-Service, Private Pay member, or Third Party Insurance, if applicable. For all members, including Private Pay, we will coordinate these services for you. See Private Pay Section.

2) Includes nurse practitioners and provider assistants who work with the provider.

**Consumer Directed Personal Assistance Services (CDPAS)**

This program lets you, or the person acting for you (also known as the "consumer"), hire, train, supervise, arrange back-up coverage, keep payroll records, and fire the person providing you with personal care services. You can ask to use the CDPAS program at any time. You can disenroll from the program at any time. Senior Health Partners will review the level of personal care services, home health aide services, and/or skilled nursing services you require and write you a plan of care.

Once Senior Health Partners finds out your needs, creates your plan of care, and tells you how many hours of services are needed, the next step will be for you to find the sufficient number of personal assistants (PAs) needed to perform the services in.
your plan of care. A PA can be almost anyone you want—a family member, friend, neighbor, or former aide—but they must be trained to do the work you need. A PA cannot be your spouse or designated representative. The consumer must work with the Senior Health Partners team to arrange covered services with providers or healthcare agencies.

As the manager of your care, the consumer is responsible for scheduling their PAs. They need to make sure that there is coverage if a PA cannot make it to work. The consumer also needs to keep track of their time worked and sign off on time sheets and other important documents.

Nursing Home Care/Long Term Placement (Permanent Placement)

Admission to one of our participating nursing homes is made on an individual basis and follows Medicaid eligibility rules. Your Care Team will make arrangements. Senior Health Partners will cover nursing home/long term placement (permanent placement) care for members who, along with their provider, agree to a nursing home/long term placement (permanent placement) stay. You must use nursing homes in the Senior Health Partners provider network. If you have any questions about nursing home care or your Medicaid or Medicare coverage, please call your Care Team.

Services for Veterans

If you want to get care from a veterans’ home, you can. Senior Health Partners works with veterans’ homes that operate in our service area. The homes can be found in the Provider Directory.

Your eligibility for veterans’ homes is based on clinical need and availability in the home. New York State veterans’ homes are limited to veterans, non-veteran spouses, and gold star parents.

If Senior Health Partners does not have a home in your service area, we will pay for you to get veterans’ home services that are out-of-network until you can transfer to another plan that has a veteran’s home in their network.

Money Follows the Person (MFP)/Open Doors

This section explains the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP if you:

- have lived in a nursing home for three (3) months or longer.
- have health needs that can be met through services in your community.

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- giving you information about services and supports in the community.
- finding services offered in the community to help you be independent.
- visiting or calling you after you move to make sure that you have what you need at home.

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors at www.health.ny.gov/mfp or www.ilny.org.

Care Planning

Care Planning and Care Management

When you enroll in Senior Health Partners, you, your provider, and your Care Team will work together to develop a Person Centered Service Plan (PCSP) to meet your healthcare needs. Your PCSP is based on your Care Team’s assessment of your healthcare needs, the recommendations of your provider, and input from you, your family, or caregivers. It will include medically necessary services to manage your current conditions. The PCSP will also include goals,
objectives, and special needs. You will get a written copy of your PCSP.

Your Care Team will monitor and evaluate your health status and care needs on a regular basis. It is important that you talk with your Care Team to let them know what you need. It is also important to let them know when you have used a non-covered service. See Covered and Non-Covered Services Section. By doing so, your Care Team will be able to manage your care in the best way possible.

Your PCSP will be updated when your care plan and services change. Your Care Team will refer and manage medical, social, educational, psychosocial, financial, and other services to meet your needs. (Please see Requesting Additional Services or Changes to the PCSP Service and Authorization for Services later in this section.)

Your PCSP is based on New York’s Uniform Assessment System (UAS), a standard assessment used to see how well you are doing and to see what health problems you have. Your Care Team will perform a re-assessment at least every six (6) months or when there are any major changes in your condition. The Care Team will also schedule a monthly care management call with you, so you can ask questions or discuss your concerns about your covered services.

A member of your Care Team will arrange the covered services that you need. This may include setting up transportation to and from all non-emergent medical appointments, providing you with home-delivered meals, and arranging for home care. They will also help you get non-covered services. For example, they may help you find providers for non-covered services, schedule appointments, or schedule transportation. Your Care Team will help you with hospital outpatient services.

A member of Senior Health Partners’ Care Team is available 24 hours a day, 7 days a week, to answer your questions.

Authorization for Services

Most of the covered services that you get must be approved by your Care Team. Some of the services also require a doctor’s order: Consumer Directed Personal Assistance Services (CDPAS), home healthcare, nursing home care, rehabilitative therapies, respiratory therapy, durable medical equipment, prosthetics, and orthotics. Non-emergent transportation, environmental supports, and home-delivered meals must be approved by your Care Team but do not require a doctor’s order. You can go to the podiatrist, dentist, audiologist, and optometrist for tests and routine services without prior approval by your Care Team. If you get these services on your own, Senior Health Partners asks that you contact a member of your Care Team.

If you need help getting any covered service, talk to any member of your Care Team. They can schedule an appointment and transportation with the provider. Emergency or urgent care services do not have to be ordered by your provider or approved by your Care Team.

Requesting Additional Services or Changes to the Person Centered Service Plan (PCSP)

Contact any member of your Care Team if:
- you or your provider feels that you need a covered service.
- you would like to change your PCSP.
- you need more in-home healthcare services.
- you need other covered services.

Your Care Team will review your request and decide if they are medically necessary. They may talk with your provider about the services and other changes you asked for.

If your Care Team approves, the service will be given and your PCSP will be changed. If your request is denied, you will get a denial letter (also known as an Initial Adverse Determination (IAD)). Senior Health Partners will give you an IAD letter when we deny or limit requested services. See Resolving Member Problems and Complaints Section.

Emergency Services

An emergency is a sudden change in medical condition or behavior that is so severe that if you do not get medical attention it would place your health in serious danger. A medical emergency can include severe pain, an injury, or sudden illness.

When you have a medical emergency, you or your caregiver should call 911. This is the best way to get
the care you need as quickly as possible. However, you can always call us. Someone will be able to help you 24 hours a day, 7 days a week.

If you need to reach us in an emergency, call 1-800-633-9717.

You do not need approval from Senior Health Partners to get emergency services. You do not need to call us for emergency services. After you get emergency care, call us as soon as possible. This will help us to handle your care in the best way.

An emergency is a medical or behavioral condition, the onset of which is sudden and so severe that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing your health or another’s in serious danger.

Care Received Outside the Senior Health Partners Service Area

If you will be out of the Senior Health Partners’ service area for a while (a few days or more), you must call your Care Team. We’re available 24 hours a day, 7 days a week at:

1-800-633-9717

Your Care Team can manage your care for up to 30 (thirty) days while you are away. During that time, we can help you with any issues you have about your care, and with getting other services.

If you are away for more than 30 (thirty) days in a row (with or without telling us), we will have to start the disenrollment process. This will begin within five (5) business days of knowing you have been away from the service area for more than 30 (thirty) days in a row.

Transitional and Specialty Care

If, before you enroll, you are being treated by a non-network provider for an ongoing course of treatment, we will pay the provider after you are enrolled. This will last for up to 60 (sixty) days or until the Person Centered Service Plan (PCSP) is in place, for any covered service that you get as part of the treatment. However, the provider must agree to accept our payment rate as payment in full, must agree to follow our policies and procedures, and must agree to provide medical information about your plan of care.

If you are being treated by a network provider for an ongoing course of treatment while you are enrolled, and the provider leaves the network, we will continue to pay the provider for any covered service that you get. This will last for up to 90 (ninety) days if the provider continues to treat you after they have left the network. However, the provider must agree to accept our payment rate as payment in full, must agree to follow our policies and procedures, and must agree to give us medical information about your plan of care.

Senior Health Partners cannot deny payment to your current providers during a transition period, even if they do not request prior authorization.

If you are transitioning with a pre-existing service plan from Medicaid Fee-for-Service (FFS) to MLTC, your first 90 (ninety) days of membership or until your PCSP has been approved, whichever is later, is covered.

Your same plan of care will be covered for the first 120 (one hundred twenty) days after enrollment as a result of: your previous plan’s closure; service area reduction; or if a merger, acquisition, or other arrangement approved by the Department of Health (DOH) has occurred or until an assessment has been made and you have agreed to the new plan of care, whichever is earlier.

Your Care Team may authorize an out-of-network provider of a covered service. Senior Health Partners will authorize it if the expertise or the service is not available in our network. Under these circumstances, we will pay for this covered service.

Disenrollment, Termination of Benefits, and Voluntary Disenrollment

You can disenroll from Senior Health Partners at any time. We will work with you and/or your representative to make sure you have a smooth transfer to another Managed Care or MLTC plan. To disenroll, you or your representative must give us an oral or written request. You can ask your Care
Team to help you with the process. If you will still need services such as personal care, your Care Team can help you get them through New York Medicaid Choice at 1-888-401-6582. You can also call them directly to join another MLTC plan, Managed Care plan, or ask for a waiver service to continue to get community-based long-term care services.

We will send you written notice (for your request to disenroll), which will begin no later than the first day of the second month after the month when you asked for disenrollment.

For private pay members, disenrollment is effective the last day of the month when disenrollment was requested. Written confirmation of disenrollment will be mailed to you after disenrollment becomes effective.

If you are enrolled in Senior Health Partners and you apply to get services from another MLTC plan, a Home and Community Based Services waiver program, or an Office for People with Developmental Disability Day Treatment program, this will begin your disenrollment from Senior Health Partners.

### Involuntary Disenrollment

There are some times when Senior Health Partners will disenroll a member from the plan. Before this happens, we will help to fix any issues (if we can). If you are being involuntarily disenrolled, you will be sent a written notice. And you will need to choose another MLTC plan or Managed Care Program, or waiver service, to continue receiving your long-term care services, such as personal care. If you do not choose a new plan, you will be auto-assigned to a new plan by New York State Department of Health (NYSDOH).

Once your disenrollment is approved by New York Medicaid Choice (NYMC), LDSS, or place chosen by the New York State Department of Health (NYSDOH), they will send you a notice of your right to a Fair Hearing. Senior Health Partners will send you written confirmation of disenrollment.

For private pay members, involuntary disenrollment does not require the approval of NYMC, LDSS, or place chosen by the NYSDOH. Private pay members do not have a right to a Fair Hearing. See Private Pay Section.

Senior Health Partners must disenroll you within five (5) business days from the date we become aware of any of the below.

- You move out of Manhattan, Bronx, Brooklyn, Queens, Staten Island, Nassau or Westchester County.
- You leave Manhattan, Bronx, Brooklyn, Queens, Staten Island, Nassau or Westchester County for any reason for more than thirty (30) days in a row with or without telling us.
- You lose your right to get benefits from the Medicaid program, and you do not want to privately pay. NOTE: Private Pay does not apply to Staten Island, Nassau, or Westchester residents.
- You are hospitalized or enter an Office of Mental Health, Office for People with Developmental Disabilities, or Office of Alcoholism Substance Abuse Services residential program for 45 (forty-five) days in a row or longer.
- You require nursing home care, but you are not eligible under the Medicaid Program’s institutional eligibility rules.
- You are no longer eligible for Medicaid benefits.
- You are not eligible for MLTC because you are assessed as no longer demonstrating a functional or clinical need for the authorization and delivery of any community-based long-term care services on a monthly basis or, for non-dual eligible enrollees who no longer meet the nursing home level of care as determined using the assessment tool prescribed by the Department. If your sole service is identified as Social Day Care, you will be disenrolled from the MLTC plan. Senior Health Partners will provide LDSS or entity designated by the Department, the result of its assessment and recommendation regarding disenrollment within five (5) business days of making such determination.
- You do not need or get at least one of these CBLTCS in each calendar month:
  - nursing services in the home
  - therapies in the home
  - home health aide services
  - personal care services in the home
  - adult day health care
➤ private duty nursing
➤ Consumer Directed Personal Assistance Services (CDPAS)

- You are incarcerated. The effective date of disenrollment will be the first day of the month following the incarceration.
- You provide us with false information, otherwise deceive us, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

Senior Health Partners may choose to disenroll you if:
- you or your family members or caregivers use bad behavior that seriously harms our ability to give services to you or others, even when we tried to stop the problems you were creating.
- you do not pay or arrange to pay your private pay (see Private Pay Section).
- you do not pay or arrange to pay your Medicaid spend down/surplus within 30 (thirty) days after it is due (even though we gave you a written demand for payment and told you that you will be disenrolled for non-payment).

Senior Health Partners cannot disenroll you because of a harmful change in your health status, or because of the medical services you use, or your reduced mental skills, or bad behavior from your medical condition or special needs.

**Effective Date of Disenrollment and Coordination of Transfer to Other Service Providers**

Your disenrollment will begin on the last day of the month after it is processed by NYMC, LDSS, or place chosen by NYSDOH. For private pay members, disenrollment begins the last day of the month that disenrollment was started. See Private Pay Section. Until your disenrollment starts, Senior Health Partners will provide covered services according to your Person Centered Service Plan (PCSP). And, during this time, your Care Team can help you find other providers to serve your care needs and transfer your care to them.

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**Re-Enrollment Provisions**

If you voluntarily disenroll, you can re-enroll in Senior Health Partners if you meet enrollment eligibility measures. If you are involuntarily disenrolled, you can re-enroll in the plan if your disenrollment issues or disputes were resolved.

**Monthly Spend Down/Surplus**

The fee that you will pay to Senior Health Partners depends on your Medicaid eligibility and its monthly spend down/surplus program. This section does not apply to private pay members. See Private Pay Section.

**If you are eligible for:**

<table>
<thead>
<tr>
<th>You will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (no monthly spend down/surplus)</td>
</tr>
<tr>
<td>Nothing to Senior Health Partners</td>
</tr>
<tr>
<td>Medicaid (with monthly spend down/surplus)</td>
</tr>
<tr>
<td>A monthly spend down/surplus to Senior Health Partners, as determined by New York City HRA or LDSS.</td>
</tr>
</tbody>
</table>

If you are eligible for Medicaid with a spend down/surplus and your spend down/surplus changes while you are a Senior Health Partners member, your monthly payment will be adjusted.

If you don’t pay (or prepare to pay) the Medicaid spend down/surplus within 30 (thirty) days after the first amount is due (even though we gave you a written notice for payment and told you in writing that you may be disenrolled), we can disenroll you.

**Resolving Member Problems and Complaints**

Senior Health Partners will handle your problems or complaints as quickly as possible. You can use our complaint process or our appeal process. If you file a complaint or an appeal, your services will not change, and we will not treat you differently. We will keep your information private. We will help you file a complaint.
or appeal. We will also give you interpreter services or help with vision and/or hearing problems. You can use someone to act for you (like a relative or friend or a provider).

To file a complaint or to appeal a plan decision, please call 1-800-633-9717, or write us at:

**Senior Health Partners Plan**  
Attn: Appeals and Complaints  
P.O. Box 5166  
New York, NY 10274-5166

If you call us, you will need to give us your name, address, telephone number, and the details of the problem. If you write to us, please include these details in writing.

What is a Complaint?

A complaint is any message from you to us of unhappiness about care or treatment you get from our team or providers of covered services. For example, if someone was rude to you or you did not like the quality of care or services you got, you can file a complaint.

The Complaint Process

You can file a complaint over the phone or in writing. We will record it, and one of our team will review your complaint. We will send you a letter telling you that we got it and give you information about our review process. You will get a written answer within a standard response timeframe or within an expedited timeframe (see below).

1. If a delayed response would risk your health, we will decide within 48 hours after we get the information, but no longer than **seven (7) days** of receiving the complaint. This is an expedited response.

2. For all other types of complaints, we will contact you within **45 (forty-five) days** of getting the necessary information, but no longer than **60 (sixty) days** of receiving the complaint. This is a standard response.

We will tell you what we found when we review your complaint. We will also give you the decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make, you can ask for a second review by filing a complaint appeal in writing. It must be filed within **60 (sixty) business days** of receiving the first decision about your complaint. When we get it, we will send you a notice with the person who will respond to your complaint appeal. All complaint appeals will be reviewed by someone who was not involved in the first decision.

For standard complaint appeals, we will give you a decision within **30 (thirty) business days** after we get all the necessary information. If a delay in making our decision would risk your health, we will use the expedited complaint appeal process. This means, we will make our appeal decision within **two (2) business days** after we get all the necessary information.

For both types of complaint appeals, we will send you a notice with our decision. It will include detailed reasons for our decision, and in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When Senior Health Partners denies or limits services you or your provider asked for; denies a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends, or stops services that are already approved; denies payment; doesn’t give timely services; or doesn’t make complaint or appeal determinations within the required timeframes, those are considered plan “actions.” An action can be appealed. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you asked for or decide not to pay for all or part of a covered service, we will notify you in writing. If we are going to restrict, reduce, suspend, or stop a service that is approved, the notice will be sent at least **10 (ten) days** before we want to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- explain the action we have taken or want to take.
n give reasons for the action, including the clinical reasoning (if any).

n describe your right to file an appeal with us (this is an internal appeal).

n describe your right to file an appeal with the State and include the process to do so (this is an external appeal).

n describe how to file an internal appeal and how you can ask that we speed up (expedite) review of your internal appeal.

n describe what we used to make the decision, if it involved issues of medical necessity or whether the treatment or service in question was experimental or investigational.

n describe the information that you and/or your provider gave us to help us make a decision on appeal.

If we are restricting, reducing, suspending, or stopping an approved service, we will also give you information on how to have services continue while we decide your appeal; how to request that the services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we take, you can appeal it. When you file an appeal, we will look again at the reason for our action to decide if we were correct. You can file an appeal of an action with us over the phone or in writing. When the plan sends you a notice about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 (sixty) days of the date on our letter notifying you of the action.

How do I Contact my Plan to File an Appeal?

Call us at 1-800-633-9717 or write to us at:

Senior Health Partners Plan
Attn: Appeals and Complaints
P.O. Box 5166
New York, NY 10274-5166

We will record your appeal, and one of our team will check the appeal. We will send you a notice that says we got your appeal. We will include a copy of your case file (medical records and other documents) that we used to make the initial decision. Your appeal will be reviewed by a member of our team who was not involved in the initial decision or action that you are appealing.

For Some Actions, You Will Continue to Get Services During the Appeal Process

If you are appealing a restriction, reduction, suspension, or termination of services you are currently approved to get, you will continue to get these services while your appeal is being decided. We will continue your service if you make your appeal request no later than 10 (ten) days from the date on the notice or the effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 (ten) days after we mail your notice about our appeal decision (if our decision is not in your favor) unless you asked for a New York State Medicaid Fair Hearing with continuation of services. See Fair Hearing Section below.

If you asked for continuation of services and your appeal decision is not in your favor, you may need to pay for these services, because you got them while your case was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited appeal review, it will be a standard review. You will get a decision notice no later than 30 (thirty) days from the day we got the appeal. You can ask for an extension (or if we need more information) of up to 14 (fourteen) days. During our review, you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your medical records that are part of the appeal review.

We will send you a decision notice with the date we made the decision. If we change our decision, we will give you the services that were denied as quickly as your health condition requires. In some cases, you may ask for an expedited appeal. See Expedited Appeal Process section below.
Expedited Appeal Process

If you or your provider thinks a standard appeal timeframe could cause a serious problem to your health or life, you can ask for an expedited review. We will give you a decision within 72 hours. The review period can be increased up to 14 (fourteen) days if you ask for an extension or we need more information and the delay is in your interest.

If we do not agree to expedite your appeal, we will contact you in person to let you know that we denied your request. We will send you a written notice of our decision within two (2) days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If your appeal decision is not in your favor, you will get a notice about your rights. The notice will give you information on how to ask for a Medicaid Fair Hearing from New York State, how to get a Fair Hearing, who can appear at the Fair Hearing on your behalf, and, for some appeals, your right to get services while the hearing is waiting to happen.

Note: You must ask for a Fair Hearing within 120 (one hundred twenty) calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of medical necessity or because the service asked for was experimental or investigational, the denial notice will tell you how to ask New York State for an external appeal.

State Fair Hearings

You can ask for a Medicaid Fair Hearing from New York State within 120 (one hundred twenty) days from the date we sent you our appeal decision.

If your appeal involved the restriction, reduction, suspension, or termination of approved services you are currently receiving, and you have asked for a Fair Hearing, you will continue to get these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 (ten) days of the date the appeal decision was sent by us or by the planned effective date of our action to restrict, reduce, suspend, or terminate your services, whichever happens later. Your benefits will continue until you withdraw the Fair Hearing, or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever happens first.

If the State Fair Hearing Officer changes our decision, we will make sure you get the services as soon as your health condition requires, but no later than 72 hours from the date we got the Fair Hearing decision. If you got the services while your appeal was waiting to happen, we will pay for the covered services ordered by the Fair Hearing Officer.

If your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were part of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp
- Mail a Printable Request Form (print out from website):
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023
- Fax a Printable Request Form (print out from website): 1-518-473-6735
- Request by Telephone:
  Standard Fair Hearing line – 1-800-342-3334
  Emergency Fair Hearing line – 1-800-205-0110
  TTY line – 711 (request that the operator call 1-877-502-6155)
- Request in Person:
  New York City
  14 Boerum Place, 1st Floor Brooklyn,
  New York 11201

For more information on how to ask for a Fair Hearing, please visit: otda.ny.gov/hearings/request.

State External Appeals

If we deny your appeal because we believe the service is not medically necessary or is experimental or investigational, you are allowed to ask for an external appeal from New York State. The external appeal will be reviewed by qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal, we will give you information on how to file an external appeal, plus give you the form you need to file an
You must file the form with the New York State Department of Financial Services within four (4) months from the date we denied your appeal.

Your external appeal will be decided within 30 (thirty) days. More time (up to five (5) business days) may be needed if the external appeal reviewer asks for more information. The reviewer will give you (and us) the final decision within two (2) business days after the decision is made.

You can get a faster decision if your provider can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that stands.”

SERVICE AUTHORIZATIONS and ACTION REQUIREMENTS

Definitions

- **Prior Authorization Review**: review of a medical request by the plan member, or provider on behalf of the plan member, for coverage of a new medical service (whether for a new timeframe or within an existing time period) or a request to change a medical service as stated in the plan of care for a new time period, before this service is given to the plan member.

- **Concurrent Review**: review of a medical request by a plan member, or provider on behalf of the plan member, for more medical services (more of the same services) that are approved in the plan of care or for Medicaid-covered home healthcare services after an inpatient admission.

- **Expedited Review**: a plan member must be given an expedited review of his or her Service Authorization Request when the plan decides or a provider says a delay would seriously jeopardize the plan member’s life, health, or ability to attain, maintain, or regain maximum function. The plan member can ask for an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

**General Provisions**

Any Action taken by Senior Health Partners for medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those that are medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered healthcare professional when the determination is based on an assessment of the plan member’s health status or the level, quantity, or delivery method of care. This requirement applies to decisions made when denying claims, because the services in question are not a covered benefit when coverage is dependent on an assessment of the plan member’s health status, and to Service Authorization Requests, including but not limited to, services included in the Benefit Package, referrals, and out-of-network services.

Senior Health Partners will tell plan members how to get help (for language, hearing, speech issues) if the member wants to file an appeal. We will give you the New York State Department of Health’s MLTC Initial Adverse Determination notice that shows you how to get help.

**Timeframes for Service Authorization Determination and Notification**

1. For Prior Authorization requests, Senior Health Partners will make a Service Authorization Determination and give the plan member the decision by phone and in writing as fast as the member’s condition requires and no more than:
   a. Expedited: **72 hours** from when the Service Authorization Request was received
   b. Standard: **Three (3) business days** after all information was received, but no more than **14 (fourteen) days** after the Service Authorization Request was received

2. For Concurrent Review Requests, Senior Health Partners must make a Service Authorization Determination and give the plan member the decision by phone and in writing as fast as the member’s condition requires and no more than:
a. Expedited: **72 hours** from when the Service Authorization Request was received

b. Standard: **One (1) business day** after all information was received, but no more than **14 (fourteen) days** after the Service Authorization Request was received

c. For Medicaid-covered home healthcare services after an inpatient admission, **one (1) business day** after the necessary information was received (except when the day after the Service Authorization Request is on a weekend or holiday), then **72 hours** from when the information was received

3. Up to **14 (fourteen) calendar day** extension. The extension may be requested by plan member or provider on the member's behalf (written or verbal). Senior Health Partners can ask for an extension if it needs more information and if the extension is in the member's interest.

   a. Senior Health Partners must notify the plan member when they ask for a review extension. The plan will explain to the member the reason for the extension, and how it is in the best interest of the member. The plan will ask the member for more information (if needed) to help make a decision, and tell them where they got the information.

4. Member or provider may appeal decision – see Appeal Procedures

5. If Senior Health Partners denied the plan member’s request for an expedited review, the plan will handle as a standard review

6. Senior Health Partners will tell the plan member if his or her request for expedited review is denied, and that their review will be standard

**Other Timeframes for Action Notices**

1. When Senior Health Partners decides to restrict, reduce, suspend, or terminate a previously approved service within an authorization period, if it is the result of a Service Authorization Determination or other Action, it will give the plan member written notice at least **10 (ten) days** before the start date of the Action, except when:

   a. the advance notice is shortened to **five (5) days** in cases of confirmed member fraud, or

   b. Senior Health Partners cannot mail the notice later than the date of notice for:

      i. plan member death

      ii. a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (where the member knows that this must be the result of supplying the information)

      iii. the member’s admission to an institution where they are ineligible for further services

      iv. the member’s address is unknown and mail directed to the member is returned with no forwarding address

      v. the member has been accepted for Medicaid services by another jurisdiction

      vi. the member’s provider prescribes a change in medical care

   c. For CBLTCS and ILTSS, when Senior Health Partners decides to reduce, suspend, or stop a previously approved service, or authorize a new period that is less than previously approved, it will give the plan member written notice at least **10 (ten) days** before the start date of the planned Action, no matter what the expiration date of the original authorization period is, except under the times described in 1(a)-(b).

   i. For CBLTCS and ILTSS, when Senior Health Partners wants to reduce, suspend, or terminate a previously approved service, or give an authorization for a new period that is less than previously approved, the Action will begin on a business day. However, if Senior Health Partners has “live” telephone coverage available 24 hours, 7 days a week, it can accept and respond to Complaints, Complaint Appeals, and Action Appeals on a non-business day.

   d. Senior Health Partners will mail written notice to the plan member on the date of the Action when the Action is a denial of payment.

   e. When Senior Health Partners does not reach a decision within the Service Authorization Determination timeframes described in this
handbook, the Action goes to the member on the date the timeframes expire.

Contents of Action Notices

1. Senior Health Partners must use the MLTC Initial Adverse Determination notice for all Actions, except for Actions that limit use of providers under the recipient restriction program (a medical review and administrative method where some members with a pattern of abusing and misusing the Medicaid program may be restricted to one or more healthcare provider).

2. For Actions that limit use of providers under the recipient restriction program, the Action notice must have:
   a. the date the restriction will begin
   b. the effect and scope of the restriction
   c. the reason for the restriction
   d. the member’s (also known as the recipient’s) right to an appeal
   e. instructions for requesting an appeal, including the right to get aid continuing if the request is made before the start date of the action, or 10 (ten) days after the notice was sent (whichever is later)
   f. the right of Senior Health Partners to assign a member a primary provider
   g. the right of the member to select a primary provider within two (2) weeks of the date of the notice of intent to restrict, if Senior Health Partners gives the member a limited choice of primary providers
   h. the right of the member to ask for a change of primary provider every three (3) months, or at an earlier time (for good cause)
   i. the right to a meeting with Senior Health Partners to discuss the reason for and effect of the intended restriction
   j. the right of the member to explain and present proof, either at a meeting or by submitting documents, showing the medical necessity of any services noted as misused in the Recipient Information Packet (a summary prepared by the pharmacist that shows misuse of pharmacy and DME services and a summary medical assessment prepared by the registered professional nurse documenting misuse of health care services and a physician must sign)
   k. the name and telephone number of the person to call to set up a meeting
   l. the fact that a meeting does not pause the effective date listed on the notice of intent to restrict
   m. the fact that the meeting does not take the place of or stop the member’s right to a Fair Hearing
   n. the right of the member to view his or her medical records
   o. the right of the member to review records kept by Senior Health Partners that show Medicare Advantage services paid for the member. This information is referred to as “claim detail” or “recipient profile” information.

Contacting the New York State Department of Health

If at any time you are unhappy with how Senior Health Partners has treated you, or how we have handled your complaint, call or write to the New York State Department of Health:

Office of Health Insurance Program Bureau of Managed Long Term Care
One Commerce Plaza, Room 1620
Albany, NY 12210
1-866-712-7197

You can also call the Independent Consumer Advocacy Network (ICAN) (also known as a Participant Ombudsman program) to get free advice about your health coverage, complaints, and appeal options. They can talk to you about a Medicaid Managed Long Term Care (MLTC) plan (like Senior Health Partners) before you decide to enroll in one. They can give you fair health plan choice counseling and general plan information. They can also help you with the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org | Email: ican@cssny.org

Senior Health Partners will work with ICAN (when needed) to help them with their duties. Senior Health Partners will also give ICAN a current list of its participating providers (if they ask for it).
Quality Assurance and Improvement Program

Senior Health Partners has a Quality Management System to track and measure the quality and importance of care and service. This detailed system must meet the New York State health and long-term care quality assurance standards.

Our Quality Management System finds opportunities for improving:

- quality of service given.
- management of care (including availability, access and continuity).
- identification and correction of operational and care management practices.
- results in clinical, non-clinical, and functional areas.

The quality management system includes a plan to look for areas where improvement is needed, a process for the continuous improvement of performance, a review of the credentials of all providers providing care or service, maintenance of health information records, and review of service use.

We welcome your suggestions about quality improvement.

Private Pay

You may be able to enroll in Senior Health Partners even if you are not eligible for Medicaid. If you agree to pay the full premium for coverage, and Senior Health Partners has not reached its enrollment limit for private pay enrollees, you may be able to enroll. Private Pay does not apply to Staten Island, Nassau, or Westchester County.

The private pay member premium is equal to the amount of the Medicaid rate as approved for Senior Health Partners by the New York State Department of Financial Services. You must pay this amount on the first day of the first full month that services are given by Senior Health Partners. You will have a one-month grace period if your premium is overdue. Senior Health Partners will send you a letter advising you of the late payment and inform you that termination can and will result for non-payment of services. You will continue to get benefits during this grace period. If your payment is not received, your enrollment will be terminated, and you must pay for the services that you got during the grace period. A written notice of termination will be provided to you. Your premium cannot be pro-rated and is not refundable.

Monthly payment to Senior Health Partners remains the same even if you experience changes in your health. Premium payments may be made by check or money order to:

Senior Health Partners
P.O. Box 48344
Newark, NJ 07101-4844

You should not cancel a Medicare supplemental policy if you have one, since you will be responsible for some Medicare copays and deductibles even after you enroll in Senior Health Partners. Unless already covered by a Medicare supplemental policy, the premium you pay to Senior Health Partners covers Medicare Nursing Home copays for days 21 to 100, durable medical equipment copays, and any Medicare copay or deductible applicable to a covered benefit. However, payment of the private pay premium to Senior Health Partners will not free you of your responsibility for any Medicare copays or deductibles for non-covered benefits. For example, private pay members are responsible for the hospital deductibles and provider copays.

Non-covered services (see Benefits and Coverage/Coordination of Other Medical Services Section) must be paid by a private pay member.

The services in this handbook also apply to private pay members. However, exceptions include, but are not limited to:

- NYC HRA/LDSS enrollment and disenrollment at the same time is not required.
- New York State Medicaid Fair Hearing cannot be requested.

These also apply to private pay members:

- New York State External Appeals process
- Senior Health Partners Internal Grievance and Appeal process (see Resolving Member Problems and Complaints Section)
- Private Pay enrollees must sign a Private Pay enrollment attestation/agreement
Notice of Non-Discrimination

**Healthfirst** complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Healthfirst** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthfirst** by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone:** 1-866-305-0408 (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email:** http://healthfirst.org/members/contact/

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- **Phone:** 1-800-368-1019 (TTY 800-537-7697)
**ATTENTION:** Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).

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<thead>
<tr>
<th>Language</th>
<th>Translation</th>
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<tbody>
<tr>
<td>English</td>
<td>ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).</td>
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<tr>
<td>Arabic</td>
<td>ملاحظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. الصل برقمه 1-866-305-0408. (TTY: 1-888-542-3821)</td>
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<td>Yiddish</td>
<td>אないですארקין: איז ב איר ראָטע אידיש. זעמאָס אמאָראָן פראָיד איר שפראָן הילַּך טעמרויָס ג’יפר, פון (TTY: 1-888-542-3821) 1-866-305-0408</td>
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<td>Bengali</td>
<td>লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃশরচ ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১১-৮৬৬-৩০৫-০৪০ (TTY: 1-888-542-3821).</td>
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<tr>
<td>Urdu</td>
<td>خبردار: اگر انگریزی بولتے ہیں، تو اپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ گال کریں। (TTY: 1-888-542-3821) 1-866-305-0408</td>
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Community Offices Near You

BRONX
East Tremont
774 E. Tremont Avenue
(between Prospect and Marmion Avenues)
Fordham
412 E. Fordham Road
(entrance on Webster Avenue)

BROOKLYN
Bensonhurst
2236 86th Street
(between Bay 31st and Bay 32nd Streets)
Flatbush
2166 Nostrand Avenue
(between Avenue H and Hillel Place)
Sunset Park
5324 7th Avenue
(between 53rd and 54th Streets)

MANHATTAN
Chinatown
128 Mott Street, Room 407
(between Grand and Hester Streets)
28 E. Broadway
(between Catherine and Market Streets)
Harlem
34 E. 125th Street
(corner of 125th Street and Madison Avenue)
Washington Heights
1467 St. Nicholas Avenue
(between W. 183rd and W. 184th Streets)

QUEENS
Elmhurst
40-08 81st Street
(between Roosevelt and 41st Avenues)
Flushing
41-60 Main Street
Rooms 201 & 311
(between Sanford and Maple Avenues)
Main Plaza Mall
37-02 Main Street
(between 37th and 38th Avenues)
Jackson Heights
93-14 Roosevelt Avenue
(between Whitney Avenue and 94th Street)
Jamaica
Jamaica Colosseum Mall
89-02 165th Street, Main Level
(between 89th and Jamaica Avenues)

LONG ISLAND (continued)

QUEENS

LONG ISLAND

LONG ISLAND

LONG ISLAND

LONG ISLAND

SUFFOLK COUNTY

Bay Shore
Westfield South Shore Mall
1701 Sunrise Highway
(in the JCPenney Wing)
Lake Grove
Smith Haven Mall
313 Smith Haven Mall
(in the Sears Wing)
Patchogue
99 West Main Street
(between West and Havens Avenues)
Shirley
La Placita
58 D Surrey Circle
(between William Floyd Parkway and Floyd Road)

WESTCHESTER COUNTY

Yonkers
13 Main Street
(between Warburton Avenue and N Broadway)

ORANGE COUNTY

Middletown
Galleria at Crystal Run
1 Galleria Drive, Lower Level
(in the Macy’s Wing)

Community office locations subject to change. For the most up-to-date locations, please visit healthfirst.org/locations.