Health Home Member Agreement Form

Member Name:
Member ID #
HH ID #
PCP ID #

By signing below, I agree to participate in the Iowa Health Home model of care. Members and providers will work closely together so that the health home can help all members with chronic diseases be as healthy as possible.

I understand that in signing this agreement to be in the Health Home that I am able to get medical treatment for my chronic condition(s) from a group of many different kinds of health care workers. The medical team and I will share information in a complete and honest way to provide overall health.

As a patient under the Health Home program, I understand that:

- It is my choice to be in a health home.
- I am a partner in my care decisions and plan of care.
- A care team will be available to help with specialty care services and referrals.
- My provider will discuss appropriate use of emergency room services.
- I have 24/7 phone access to the care team.
- If I am a current Medi-Pass or HMO member, I will leave that program so I may participate in the Health Home program.
- I can choose to leave the Health Home program but will re-join the Medi-Pass or HMO, if I qualify.
- I cannot change programs more than once a month.
- I will receive a confirmation letter with the start date of my health home enrollment.

Please call *Member Services* at 1-800-338-8366 or locally in the Des Moines area at: 515-256-4606 with any questions.

Please print and sign your name below if you want to participate in the Health Home.

_____	_____	_____
Printed Member Name	Member Signature	Date
_____	_____	_____
Printed Parent/Guardian Name	Parent/Guardian Signature	Date

*For members under the age of 18 years of age.

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