SAN FRANCISCO HEALTH PLAN
Here for you

SAN FRANCISCO HEALTH AUTHORITY AGREEMENT FOR PERSONAL REPRESENTATIVE FORM

Federal law requires San Francisco Health Plan (SFHP) to protect the privacy of information that identifies you and relates to your past, present, and future physical and mental health and conditions ("protected health information").

Completion of this form assigns you a Personal Representative of your choice. Your Personal Representative will be authorized to make health care related decisions or requests on your behalf.

Completion of this form also allows the individual to act as your Authorized Representative for a grievance or appeal, including any external review rights that are available to you.

Fill out all the information on this form. You will not get a Personal Representative if the form is missing information. San Francisco Health Plan (SFHP) keeps your health information safe and private.

- You agree that you want a Personal Representative. You understand that you do not need to sign this form. You agree to sign this form only if you decide to get a Personal Representative.

  SFHP will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization. You may cancel this authorization at any time. You can revoke verbally or in writing. You understand that your revocation of a Personal Representative will not apply to any information that has already been released in reliance on this authorization.

- SFHP will not share your medical information about Sensitive Services with anyone without your written agreement. You do not need someone else's permission to get Sensitive Services or to submit a claim for Sensitive Services if you have the right to consent. You may need to be a certain age or have sufficient capacity to consent depending on the type of Sensitive Services.
  - Sensitive Services can be for mental or behavioral health, sexual and reproductive health, sexually transmitted infections (including HIV and AIDS), alcohol or drug problems, transgender care, and violence from my family or partner.
  - This form does not authorize the sharing of protected health information including Sensitive Services. A separate authorization form is required to authorize the sharing of protected health information, including Sensitive Services.

- You agree that this authorization will continue to be valid as long as you are enrolled with SFHP, with exceptions stated in this form such as the expiration date and your right to revoke the authorization at any time.

- SFHP can decide to stop your Personal Representative. SFHP will end your Personal Representative if there is reasonable belief that:

  1) You are subject to domestic violence, abuse, or neglect by that person,

  2) Treating such person as the Personal Representative could endanger you, or

  3) In the exercise of professional judgment SFHP decides it is not in your best interests to treat the designated individual as your Personal Representative.

- You have a right to get a copy of this authorization upon request.

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After you sign this form save a copy for you.

Mail or fax the form to:
San Francisco Health Plan
Attn: Compliance Officer
P.O. Box 194247
San Francisco, CA 94119
Fax: 1(415) 547-7825

I agree to the use the Personal Representative named below:

My Information:

My Name: _____ My Birth Date: _____

My Address: _____

City, State, Zip: _____ Phone #: _____

Health Plan: _____ ID #: _____

Personal Representative Information:

Name: _____ Birth Date: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Relationship to Member: _____

_____

START AND END DATE OF YOUR PERSONAL REPRESENTATIVE

(Please write "N/A" if you do not want to stop using a personal representative on a certain date.)

Don't forget: You can end the use of a Personal Representative at any time.

My Personal Representative starts on _____ and will end on _____

SIGNATURES

Date: _____ Time: _____ AM/PM

Signature: _____

(My Information)

Date: _____ Time: _____ AM/PM

Signature: _____

(My Personal Representative)

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The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-415-547-7800**) or (**1-800-288-5555**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been resolved satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at **1(888) 452-8609.** Hours of Operation are Monday through Friday, 8:00am to 5:00pm PST, excluding holidays.

You can also get help from your doctor, or call SFHP's Customer Service Department at **1(415) 547-7800**, **1(800) 288-5555** (toll-free) or TTY **1(888) 883-7347.** Our office hours are from 8:30am to 5:30pm, Monday through Friday.