Keystone First
Community HealthChoices
200 Stevens Drive
Philadelphia, PA 19113

Keystone First
Community HealthChoices

Tips to Appoint Personal Representative

You may appoint another person to make health care decisions for you. To appoint this person to be your personal representative, you will need to complete the form we sent with this letter. You will also need to provide legal documentation showing that the person you are appointing as your personal representative has the legal right to act for you.

Important information about this form

By completing this form, you allow the person you name on this form to make health care decisions for you. You also allow us to share your protected health information (PHI) with the person as permitted by law. For your PHI to be shared with anyone else, you must give your consent, unless otherwise permitted by law.

Follow the steps below to appoint a person to make health care decisions for you.

1. Fill out the form we sent with this letter. **Or** ask your personal representative to fill out the form.
2. Have your personal representative sign the form.
3. Provide legal documentation showing that the person you are appointing as your personal representative has the legal right to act for you.
4. Send the completed form back to us.

You can mail it to:

Keystone First Community Health Choices
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

If you have any questions about this letter or the form we sent with the letter, we can help. Just call Participant Services at **1-855-332-0729 (TTY 1-855-235-4976)**.

Personal Representative Form

Please print clearly in blue or black ink.

Keystone First
Community HealthChoices

In order for this Personal Representative Form to be processed by Keystone First Community HealthChoices (CHC):

- The form must be completely filled out.
- A copy of the legal document referred to on this page must be attached to this form.

The Personal Representative Form lists the person who has legal authority to act on your behalf to make health care decisions. This information will remain on file with Keystone First CHC until revoked by you, or revoked by a court order or law.

If you have questions, please call Participant Services at **1-855-332-0729 (TTY 1-855-235-4976)**.

Participant information		
First name:	Last name:	Middle initial:
Participant ID (see ID card):	Date of birth (MM/DD/YYYY):	
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
Home phone number (including area code):		
Mobile phone number (including area code):		
Email address:		

Personal representative information		
First name:		Middle initial:
Last name:		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
Home phone number (including area code):		
Mobile phone number (including area code):		
Email address:		
Relationship to Participant:	Date of birth (MM/DD/YYYY):	

A copy of legal documentation must be attached to this form.
If you do not attach legal documentation, this form cannot be processed.

Type of document you are attaching:

☐ Health care power of attorney	☐ Other (please explain):
☐ Guardianship court order (for health care decisions)	
☐ Custodial court order	
☐ Executor/Executrix of estate (Participant is deceased)	

Signature and date of Participant's legal personal representative	
Name (print):	
Personal representative's signature:	Date (MM/DD/YYYY):

Please keep a copy of this form for your records.

Important information about personal representatives

The federal Privacy Rule requires Keystone First Community HealthChoices (CHC) to follow certain steps before it may provide access to your protected health information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition and the provision of health care to you or the payments for that care. Keystone First CHC will release PHI to your personal representative after we receive a document that supports their legal authority to make health care decisions on your behalf (for example, a valid power of attorney, guardianship, or other legal document). Keystone First CHC will also recognize as a personal representative an executor, an administrator, or a person recognized by law as having authority to act on behalf of a deceased Participant or the Participant's estate.

We care about your privacy

Information about your health is very personal. We are committed to protecting your privacy. Please read this form carefully. This form will need to be entirely filled out for it to be processed. This includes attaching legal documentation.

Keystone First CHC will not treat someone as your personal representative if we reasonably believe: (1) you may be subject to domestic violence, abuse, or neglect by the personal representative; (2) treating the person as your personal representative could put you in danger; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), Keystone First CHC decides that it is not in your best interest to treat the person as your personal representative.

We care about your well-being

We care about your well-being. If we think your personal representative will misuse your health information, we will not give it to them.

A personal representative designation will remain in effect until the Participant, a court order, or a law revokes it.

Completing the form

If you name a personal representative, this form will remain in effect until it is canceled. You can cancel this authority at any time. You just have to tell us by calling Participant Services at **1-855-332-0729 (TTY 1-855-235-4976)**. A court order or other laws can also cancel it.

To help Keystone First CHC respond to this request, please complete this form by printing or typing into the spaces provided. Attach more pages if needed to make your request clear. Attach a copy of the document that says your personal representative has legal authority to act on your behalf.

Where to mail the form

Mail the completed form **and** supporting document to:

Keystone First Community HealthChoices
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

Questions? Call Participant Services at **1-855-332-0729 (TTY 1-855-235-4976)**.

Keystone First

Community HealthChoices

Nondiscrimination Notice

Keystone First Community HealthChoices complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Keystone First Community HealthChoices does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Keystone First Community HealthChoices provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Keystone First Community HealthChoices provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **Keystone First Community HealthChoices** at **1-855-332-0729 (TTY 1-855-235-4976)**.

If you believe that **Keystone First Community HealthChoices** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Keystone First
Community HealthChoices,
Participant Complaints Department,
Attention: Participant Advocate,
200 Stevens Drive
Philadelphia, PA 19113-1570
Phone: **1-855-332-0729**, **TTY 1-855-235-4976**,
Fax: **215-937-5367**, or
Email: PAmemberappeals@amerihealthcaritas.com

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: **(717) 787-1127**, TTY/PA Relay **711**,
Fax: **(717) 772-4366**, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Keystone First Community HealthChoices and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue S.W.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, **800-537-7697** (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.

Call: **1-855-332-0729 (TTY 1-855-235-4976).**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-332-0729 (TTY 1-855-235-4976).**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-332-0729(телетайп: 1-855-235-4976)**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-332-0729 (TTY 1-855-235-4976)**。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-332-0729 (TTY 1-855-235-4976).**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-855-332-0729** (رقم هاتف الصم والبكم: **1-855-235-4976**).

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-855-332-0729 (टिटिवाइ: 1-855-235-4976)** ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-332-0729 (TTY 1-855-235-4976)** 번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-855-332-0729 (TTY 1-855-235-4976)**។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le **1-855-332-0729 (ATS 1-855-235-4976).**

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် **1-855-332-0729 (TTY 1-855-235-4976)** သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-855-332-0729 (TTY 1-855-235-4976).**

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-855-332-0729 (TTY 1-855-235-4976).**

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-855-332-0729 (TTY 1-855-235-4976).**

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-855-332-0729 (TTY 1-855-235-4976).**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-855-332-0729 (TTY 1-855-235-4976).**