NH Department of Health and Human Services
Granite Advantage Health Care Program
P.O. Box 3778, Attn: Granite Advantage Health Care Program Manager
Concord, NH 03302-3778
Fax 603-271-5623

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Exemption Request Form
Granite Advantage Health Care Program

Use this form to request an exemption from the Granite Advantage Community Engagement requirements. **DETAILED INSTRUCTIONS ARE ENCLOSED.** If a licensed medical professional must certify the exemption, ask them to complete the Section III. Please note you can find your Medicaid ID Number (MID) in the lower left hand front corner of your blue Medicaid card that has **State of New Hampshire** on the front. If you are unable to locate your MID number, you may enter your birth date instead.

Name:

Last ___.___.___.___.___.___.___.___.___.___.___.___. First ___.___.___.___.___.___.___.___.___.___.___.___.

Medicaid ID#: ___.___.___.___.___.___.___.___.___.___.___. Date of Birth ___.___. ___.___. ___.___.___.___.

Section I. Self-attested exemptions and exemptions requiring beneficiary ACTION		
O	Participation in State Certified Drug Court Program	Attach a copy of the legal documentation
O	Parent/Caretaker of Dependent Child Under 6	Enter the child's DOB in the box at the bottom of the page
O	Pregnant or Within 60 Days Post-partum	Due Date:

By filling in the circle for an exemption in Section I or II below and signing this form, I attest under penalty of unsworn falsification pursuant to RSA 641:3 that the information provided to the department in support of this request is true to the best of my knowledge and belief.

_____ _____
Beneficiary Signature Date

Section II. Exemptions requiring CERTIFICATION BY A LICENSED MEDICAL PROFESSIONAL		
O	Disability	Licensed Medical Professional
O	Caretaker Residing With Immediate Family Member with Disability	Licensed Medical Professional
O	Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient Treatment	Licensed Medical Professional
O	Inpatient Hospitalization	Licensed Medical Professional
O	Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness	Licensed Medical Professional
O	Parent/Caretaker of Developmentally Disabled Child	Licensed Medical Professional
O	Parent/Caretaker of Family Member Requiring Care	Licensed Medical Professional

For the **Inpatient Hospitalization** exemption, enter the hospital admitted date below:

Admitted Date: ___.___. ___.___. ___.___.___.___.

For any Parent or Caretaker exemption, enter the information for the person being cared for below:

Full Name: ___.___.___.___.___.___.___.___.___.___.___.___. ___.___.___.___.___.___.___.___.___.___.___.___.

Last First

Date of Birth (MMDDYYYY): ___.___. ___.___. ___.___.___.___.

Section III. Licensed Medical Professional Section

As a licensed medical professional caring for this beneficiary, I hereby certify (based on the description of the exemptions provided in the instructions to this form) that the beneficiary meets the qualifications for the exemption(s) requested in Section II.

This certification is valid through (may not exceed one year): ___.___. ___.___. ___.___.___.___.

Provider Name (Please Print):	NPI #: ___.___.___.___.___.___.___.___.___.___.
Date:	Contact #: ( )

Provider Signature: _____

Instructions For Completing the Form

Beneficiary Instructions:

1. Complete your beneficiary information and sign the top section of the form. Please note you can find your Medicaid ID Number (MID) in the lower left hand front corner of your blue Medicaid card that has **State of New Hampshire** on the front. If you are unable to locate your MID number, you may enter your birth date instead.
2. After reviewing the description of the various exemptions below, fill in the circle in the far-left column of the row which applies to the exemption(s) that you are requesting.
3. If you are requesting an exemption as a parent or a caretaker, enter the name and DOB of the person being cared for.
4. If the exemption type requires certification by a licensed medical professional, request that the licensed medical professional complete Section III of the form.
5. You MUST return this form to the Department of Health and Human Services either by mail at the address on top of the first page, by fax to 603-271-5623, by submitting the form to your NH EASY account, or bringing the form to your local district office. You may submit to NH EASY or bring to your local district office the exemption form that requires certification by a licensed medical professional ***only*** if the licensed medical professional has certified that you meet the qualifications for an exemption.

Licensed Medical Professional Instructions:

1. Review the Description of Exemptions below and the exemption(s) that the beneficiary has selected in Section II of the form for accuracy.
2. Enter the certification end-date for the exemption if known.
3. Fill in your provider information and sign the bottom section of the form.
4. If you are submitting this form on behalf of the beneficiary, please send it to the return address on the front page, or fax it to 603-271-5623.

Description of Exemptions

Participation in State Certified Drug Court Program	The beneficiary is participating in a state certified drug court program that has been certified by the administrative office of the superior court. This requires a copy of the legal documentation requiring the beneficiary to participate in the state drug court program.
Parent/Caretaker of Dependent Child Under 6	The beneficiary is a custodial parent or caretaker of a dependent child under 6 years of age. Enter the name and DOB of the child.
Pregnant or Within 60 Days Post-partum	The beneficiary is pregnant or within 60 days post-partum. Enter the due date.
Disability	The beneficiary has a disability as defined in He-W 837.01(h) and is unable to comply with the community engagement requirement due to disability-related reasons. This exemption requires that a licensed medical professional certify the disability.
Caretaker Residing With Immediate Family Member with Disability	The beneficiary resides with an immediate family member who has a disability as defined in He-W 837.01(h)and is unable to meet the community engagement requirement for reasons related to the disability of that family member. This exemption requires that a licensed medical professional certify the family member's disability.

Illness, Incapacity or Treatment Including Inpatient or Residential Outpatient SUD Treatment	The beneficiary is unable to participate in the requirements due to illness, incapacity, or treatment. This exemption includes the beneficiary's participation in inpatient and residential outpatient substance use disorder treatment or in intensive outpatient substance use disorder services that is consistent with ASAM Levels 2.1 and above. This exemption requires a licensed medical professional certify the illness, incapacity or treatment including inpatient or residential outpatient treatment.
Hospitalization	The beneficiary experiences a hospitalization. This exemption requires copies of discharge summaries, or financial or billing information, documenting the hospitalization or dates of stay.
Caretaker Residing With Immediate Family Member Who Experiences Hospitalization or Serious Illness	The beneficiary resides with an immediate family member who experiences a hospitalization or serious illness. This exemption requires copies of discharge summaries, or financial or billing information, documenting the hospitalization or serious illness or dates of stay.
Parent/Caretaker of Developmentally Disabled Child	The beneficiary is a custodial parent or caretaker of a child with developmental disabilities who is residing with the parent or caretaker. This exemption requires that a licensed medical professional certify the child's developmental disability.
Parent/Caretaker of Family Member Requiring Care	The beneficiary is a custodial parent or caretaker who is required to be in the home to care for another relative who resides in the same household due to that individual's illness, incapacity or disability and there is no other household member to provide the care.