

What is the Health Partnership Program?

Medi-Share members recognize and value the relationship between personal health responsibility and healthcare cost savings. The healthier our community is as a whole, the better stewards we can be with our sharing dollars at Medi-Share.

In 2004, Medi-Share members voted to establish the Health Partnership Program in order to provide health coaching and support to any member identified upon application with certain evidence-based health risk factors. The Health Partnership Program is here to help our members avoid developing any preventable chronic disease and manage current health conditions with evidence-based lifestyle therapy.

Once a member is enrolled, they can meet with a coach right away and discuss their unique and specific situation together. We want to hear everyone's personal story & tailor your experience to meet your needs!

To help you reach the required goals to graduate from the Health Partnership program and have the fee removed, we will provide you resources to support your efforts, which include an online portal and access to telephone based coaching:

- Registered Dietitian Nutritionist
- One-on-one telephonic health coaching for goal setting and accountability
- Meal plans and nutrition guides created by a Registered Dietitian
- Exercise plans designed by certified personal trainers
- Exclusive online health education portal from a Biblical foundation
- Fitness wearable devices and fitness challenges
- Biblical perspective, encouragement and prayer

The Health Partnership program and the related \$99 monthly fee are required for members with specified health indicators, as identified in the chart below:

Health Partnership Outcome Goals					
Risk Factor	Required to Graduate	Optimal Health	Risk Factor	Required to Graduate	Optimal Health
Weight (BMI)	From 17.5 - 31.9	18.5 – 24.9	Total cholesterol*	Under 220	Under 150
Waist – men	Below 41"	Below 34"	HDL - men/women*	≥35/≥42	60 or higher
Waist – women	Below 38"	Below 30"	LDL*	Below 150	Below 70
Blood pressure	Below 135/90	Below 115/75	Triglycerides*	Below 200	Below 100
			HbA1c	4.2 to 5.9	4.2 – 5.2

*Lipid panel/Blood Sugar should be fasting.

In order to graduate and have the fee removed, I will:

1. Submit self-reported weight / waist / blood pressure and verification for cholesterol and HbA1c demonstrating that I have achieved the goals above.

** If you have already achieved the goals in the chart above and are participating in the Health Partnership program because of a condition identified in your Application Review Report in the Forms Center, the program requires that you have three contacts with a coach in order to graduate.*

2. I understand that upon graduation from the Health Partnership program, I will be required to re-verify my results annually for a period of three years. If any of the re-verification metrics are not in line, I understand that I will be re-enrolled in the Health Partnership program and the \$99 monthly fee will be added to my monthly share notice. Upon the subsequent graduation, the three year verification process will restart.

Health Partnership Acknowledgement

I understand Coaches do not diagnose, prescribe for, or treat disease, illness or injury, and that any and all medical issues should be discussed with my physician. I understand that I am not to participate in any activity that my physician says would not be safe for me, including but not limited to diet and exercise, and will disclose to my Coach any health concerns or limitations that could affect my health. I understand my coach may require me to get a medical clearance for exercise from my physician. I agree to apply proper guidelines for safety and technique in performing exercise, and to progress at a safe pace. I understand that there are risks while exercising, such as incurring physical injury to bone, muscle, ligament, or tendons and in very rare instances, life threatening problems such as heart attack or stroke. I understand that I am to stop exercising and consult with my physician and/or call 911 if I develop symptoms of lightheadedness, dizziness, difficulty breathing, chest/shoulder/neck/jaw pain or pain radiating to the back during or following an exercise session. I realize coaching calls are recorded for quality assurance. Being fully apprised of and aware of these risks, I fully accept and assume such risks, and the possibility of personal injury, property damage, or other loss, and waive all claims related to such risks.

By signing below I certify that I have read this form in its entirety, and agree to its terms, and affirm that all information that I have entered or supplied is accurate.

Signature _____

Date _____