The Iowa AIDS/HIV Health Insurance Premium Payment Program

Iowa Department of Human Services

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What is the AIDS/HIV Health Insurance Premium Payment (HIPP) program?

The AIDS/HIV HIPP program is administered by the Iowa Department of Human Services (DHS). The purpose of this program is to maintain health insurance coverage, by paying the health insurance premium, for persons living with AIDS or HIV-related illnesses.

How do I qualify for the AIDS/HIV HIPP program?

You must meet all of the following criteria in order to be determined eligible for premium payment under this program:

- You are currently the policyholder or the spouse of a policyholder of a group or private health insurance plan.
- You file a completed AIDS/HIV Health Insurance Premium Payment Application, form 470-2953, with the Department of Human Services. (A copy of this form is included with this booklet.)
- You provide a completed Physician's Diagnosis Verification form, on which your physician verifies you have been diagnosed with AIDS or an HIV-related illness. The physician must also certify that, due to this illness, you are either too ill to continue working in your current job (including a reduction from full - time to part - time employment) or are very likely not to be able to work within six (6) months. (A copy of this form is included with this booklet.)
- You are a resident of Iowa.
- Your gross earned income and unearned income (as defined by the Supplemental Security Income (SSI) program) does not exceed 300% of the federal poverty level. As of January 1, 1995 these limits are as follows:

Family Size	Monthly Income Limit
1	$1,935.00
2	$2,590.00

For each additional person add $655.00

- Your "cash" assets (bank accounts, stocks, bonds, etc.) do not exceed $10,000.
- Your are not eligible for Medicaid (Title 19). Persons who must meet a spenddown obligation under the Medically Needy program are not considered Medicaid eligible for the purposes of the AIDS/HIV HIPP program. If you are eligible for Medicaid, premiums may be paid under the Health Insurance Premium Payment (HIPP) program for Iowa Medicaid recipients.

Will DHS find health insurance for me?

No. DHS will pay premiums for a health insurance plan in which you are already enrolled. The insurance may be a group plan through an employer/previous employer, an organization of which you are a member, or a private health insurance plan.

If I have family group health insurance, will DHS pay the premium?

When you are enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain your coverage will be paid unless modification of the policy (changing from family to single coverage) would result in a loss of coverage for you.

How do I apply?

You may apply by completing the AIDS/HIV Health Insurance Premium Payment Application, included with this booklet, and mailing it to the Department of Human Services in the enclosed postage - paid envelope or by taking it to any county DHS office.

How long will it take to determine if I am eligible for the program?

Every reasonable effort will be made to make a decision regarding your eligibility within 30 days from the date a completed application form is received by the Department. Additional time for making a decision may be taken when, due to circumstances beyond the control of you or the Department, a decision regarding your eligibility cannot be reached within the 30 days.

What kind of verification and documentation do I have to provide?

In addition to providing a Physician's Verification of Diagnosis, you are required to verify all of your income and cash assets and those of any family members whose income and resources are considered in the eligibility determination. Documentation may include, but is not limited, to the following:

- ***Earned Income*** --Pay stubs for the past 30 days, income tax returns, self - employment records, employer's statements, etc.
- ***Unearned Income*** --An award letter verifying benefits such as disability or Veteran's benefits, court documents verifying child support payments received, etc.
- ***Cash Assets*** --Bank statements, stock portfolios, copies of certificates of deposit, etc.

Insurance policy --A premium statement, bill, or employer statement to verify the amount of the premium and the frequency it is paid. Additionally, you need to provide a benefit booklet or plan summary describing the services covered under your insurance plan.

My insurance policy is going to lapse because I can't pay the premium --- what can I do?

If your insurance policy is going to lapse due to non-payment of premiums, you may be "presumed" eligible to participate in the program for up to two calendar months, pending a formal eligibility determination. In order to be presumed eligible, it must be reasonably anticipated you will be found eligible for the program based on the income and resources listed on the application. Additionally, your application must be accompanied by a completed Physician's Verification of Diagnosis form and a current premium statement from the insurance carrier indicating the policy will lapse before a decision regarding your eligibility can be made.

How long will DHS pay for my insurance?

Once you are determined eligible to participate in the program DHS will continue to pay your insurance premium as long as all eligibility requirements are met and as long as funding for the program is available. A review of your eligibility will be completed every three months.

How soon will premium payments begin?

Premium payments will begin with the month in which you filed the application or the first month in which you meet all program requirements, whichever is later.

However, no premiums will be paid for any time period if you are not eligible for insurance on the day a decision regarding your application is made (e.g. the policy has lapsed).

How will the premiums be paid?

Whenever possible, DHS will make arrangements to pay the health insurance premium directly to the insurance carrier. When the employer makes a payroll deduction, DHS will ask the employer to agree to accept payment from DHS instead of deducting the insurance payment from your earnings. If the employer will not agree, DHS will reimburse the policyholder directly for the payroll deduction made for health insurance.

What are my responsibilities once I am enrolled in the program?

You are required to provide information, when requested to do so, in order to establish your continued eligibility for the program. You must apply for Medicaid (Title 19) if requested to do so. Additionally, you are required to report changes in your circumstances within 10 days. These include, but are not limited to:

- A new address
- Changes in the amount of your insurance premium or the services covered under the plan
- Changes in income or assets

Further Questions

If you have any questions regarding this program or need assistance completing the application form, please contact the Department by writing to:

Iowa Department of Human Services
Division of Medical Services/HIPP
5th Floor - Hoover State Office Building
Des Moines, Iowa 50319-0114

or by calling **515-281-7313 or 515-281-7151** (collect phone calls are accepted).

Confidentiality

All information required by the Department in administering the AIDS/HIV Health Insurance Premium Payment program will be maintained in the strictest confidence. Information will not be disclosed to any other individual or organization without written consent of you or your representative.

Appeals

If you are dissatisfied with the actions or lack of action by DHS, you should discuss the matter with your worker. If a satisfactory agreement cannot be reached, you have a right to file for an appeal and ask for a hearing. If a hearing is allowed, it will be an informal meeting before an administrative law judge from the Department of Inspection and Appeals. All the facts will be reviewed to see if the decision was correct or should be changed. You may file an appeal to ask for a hearing by writing to your county Department of Human Services Office or by writing to:

Appeals Section
Division of Policy Coordination
Iowa Department of Human Services
Hoover State Office Building
Des Moines, Iowa 50319-0114

If you feel the "Notice of Decision" is incorrect, you may file an appeal within 30 days of the date on the notice which will protect your right to a hearing. Discussions with your worker or other DHS staff do not extend this time limit.

Filing an appeal before the effective date on the "Notice of Decision" can allow your benefits to continue until your appeal is heard or decided.

POLICY ON NONDISCRIMINATION

No person shall be discriminated against because of race, color, national origin, sex, age, mental or physical disability, creed, religion, or political belief when applying for or receiving benefits or services from the Iowa Department of Human Services, or any of its vendors, Purchase-of-service providers, or contractors.

If you have reason to believe that you have been discriminated against for any of the above reasons, you may write to the Department of Human Services, the Iowa Civil Rights Commission (if you feel you were treated differently BECAUSE OF your race, creed, color, national origin, sex, religion, or disability), and/or the United States Department of Health and Human Services.

Office of Equal Opportunity
Iowa Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, IA 50319-0114

Iowa Civil Rights Commission
211 E. Maple Street, 2nd Floor
Des Moines, IA 50309-1858

U.S. Department of Health and Human Services
Office for Civil Rights, Region VII
601 E. 12th Street, Room 248
Kansas City, MO 64106

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Iowa Department of Human Services
PHYSICIAN'S DIAGNOSIS VERIFICATION

PART I — *To Be Completed by Applicant (Patient)*

Patient Last Name	First Name	MI

Social Security Number	Birth Date

Address	County

City	State	Zip

Authorization for Physician's Release of Information

I hereby authorize my physician, named in Part II, to furnish the Iowa Department of Human Services confidential medical information (including HIV-related test results) for the purpose of determining my eligibility for the AIDS/HIV Health Insurance Premium Payment (HIPP) program. I hereby and forever release and discharge my physician from any liability for divulging such information, notwithstanding the fact this authorization expires 120 days after the date of my signature.

Patient's Signature _____ Date _____

INSTRUCTIONS FOR COMPLETION OF FORM

It may shorten your eligibility process if you call your physician's office first and schedule an appointment to have him or her complete this form. Do not just drop into your physician's office. This may delay completion of the form. Once the form is completed you should then mail it, along with your application, in the envelope provided or to the address below.

If this is not possible, this form may be left with your physician for completion later. As soon as the form is completed, either you or your physician should submit it to the address below:

Iowa Department of Human Services
Division of Medical Services/HIPP
5th Floor - Hoover Bldg.
Des Moines, Iowa 50319-0114

PART II — *To Be Completed by the Applicant's Physician*

This person has tested positive for Human Immunodeficiency Virus (HIV). If yes, attach copy of the most recent laboratory test result, if available. ☐ YES ☐ NO

It is my judgement this patient is too ill to continue working in his or her current position or will have to reduce the number of hours of employment because of HIV-related disease. (Explain) ☐ YES ☐ NO

It is my judgement there is a substantial likelihood that within approximately six months this patient will be unable to work because of HIV-related disease. (Explain) ☐ YES ☐ NO

REMARKS: Please use the space provided below for additional comments on any of the above items.

Physician's Name: _____

Office Address: _____

_____

City State ZIP

Phone: ( ) _____ Medicaid Provider Number: _____
(If Known)

_____

Physician's Signature Date

ADDITIONAL COMMENTS

State of Iowa

AIDS/HIV HEALTH INSURANCE PREMIUM PAYMENT APPLICATION

GENERAL DIRECTIONS

The information on this form will be used in determining eligibility for the AIDS/HIV Health Insurance Premium Payment (HIPP) program. All questions must be completed and the form signed by the applicant or the applicant's representative. The applicant is the person diagnosed with AIDS or Human Immunodeficiency Virus (HIV). A representative is a spouse, parent, relative, guardian, employee of a public or private agency, or other person most familiar with the applicant's situation and financial status. If able, the applicant should review the form for accuracy and completeness when it has been completed by a representative. The person signing the form is responsible for the accuracy and completeness of the information provided.

To help us process the application as quickly as possible, please submit the following information with the completed application form.

- A completed Physician's Diagnosis Verification (form 470-2958)
- A copy of your insurance benefit booklet or a summary statement identifying the services covered under the insurance plan.
- Verification of the amount and frequency of the insurance premium.
- Verification of all income and assets as indicated on pages 3 and 4 of the application form.

Use the space provided on the last page if additional space is needed for your answers.

PART I - APPLICANT

Last Name	First	MI	Telephone Number ( )
Address			County
City		State	Zip
Soc. Sec. Number	Birth Date	Sex ❑ Male ❑ Female	Race

PART II - APPLICANT REPRESENTATIVE (Spouse, Parent, Friend, etc.):

Answer this question only if a representative completes, or assists in the completion of this form.

Last Name	First	MI	Relationship to Applicant
Address			Telephone Number ( )
City		State	Zip

PART III - INSURANCE: Complete the following information regarding the insurance policy. Please submit a copy of your benefit booklet or benefit summary and verification of the amount of the premiums with this application.

Name and Address of Insurance Carrier

Policyholder Name
Policy Number
Your Cost for Premiums $
How Often is Premium Due?

A. Type of policy (check one): ❑ SINGLE COVERAGE ❑ FAMILY COVERAGE

❑ OTHER (e.g. employee & spouse, etc. - explain) _____

B. Effective date of coverage: _____

C. Source of insurance (check one): ❑ Employer Group Plan ❑ Private Plan

❑ Other (explain) _____

D. **If employer group**, list name and address of employer/former employer: _____

E. **If employer group**, is this a COBRA or continuation plan? ❑ YES ❑ NO

F. **If yes**, date COBRA or continuation eligibility began: _____

When will eligibility for COBRA or continuation coverage end? _____

PART IV - FAMILY: Information about the Applicant and the Applicant's Family

A. Applicant is (check one): ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

B. **If married**, does your spouse live with you? ❑ YES ❑ NO **If yes, complete the following**

Last Name	First	MI	Birth Date	Soc. Sec. #

C. Do you have any natural or adopted unmarried children under the age of 21 living with you?

❑ YES ❑ NO **If yes, complete the following**

Last Name	First	MI	Birth Date	Soc. Sec. #
			/ /	
			/ /	
			/ /	

D. Is anyone in your household receiving Medicaid (Title 19) ? ❑ YES ❑ NO

If yes, list names: _____

PART V - INCOME: For each source of income below, fill in how much each person expects to receive from that source and how often the income is received (weekly, biweekly, monthly, etc.). Put "O" in all empty $ spaces. PLEASE PROVIDE CURRENT PROOF OF ALL SOURCES OF INCOME, IF AVAILABLE AT THIS TIME.

	APPLICANT		SPOUSE		CHILDREN	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
A. SALARY OR WAGES — Gross salary **before** payroll or pre-tax deductions.	$		$		$	
B. PROFIT FROM SELF-EMPLOYMENT	$		$		$	
C. COMMISSION OR TIPS — Gross **before** deductions.	$		$		$	
D. UNEMPLOYMENT — In addition to completing "how often?", enter how many weeks are left.	$	**Weeks left**	$	**Weeks Left**	$	**Weeks Left**
E. WORKERS COMPENSATION	$		$		$	
F. SOCIAL SECURITY BENEFITS — Gross **before** medicare deductions.	$		$		$	
G. OTHER DISABILITY BENEFITS — Gross **before** deductions.	$		$		$	
H. PENSION OR RETIREMENT BENEFITS — Gross **before** deductons.	$		$		$	
I. DIVIDENDS AND INTEREST	$		$		$	
J. INCOME FROM PROPERTY	$		$		$	
K. OTHER INCOME — (money from friends or relatives, child support, etc.). List source of income.	$	**Type or Source**	$	**Type or Source**	$	**Type or Source**
TOTAL	$		$		$	

PART VI - RESOURCES: Fill out a column for each person. Put "O" in the empty $ spaces. If you share a resource with someone else, enter how much of the resource belongs to you. PLEASE PROVIDE CURRENT PROOF OF ALL RESOURCES IF AVAILABLE AT THIS TIME.

	APPLICANT	SPOUSE	CHILDREN
A. CASH ON HAND	$	$	$
B. CHECKING ACCOUNT — Enter how much each person has in the account. Enter the name of the bank and the account number. If this is a joint account with two (2) or more names, list the other owners.	**Bank:** **Account No:** $	**Bank:** **Account No:** $	**Bank:** **Account No:** $
C. SAVINGS ACCOUNT — Enter how much each person has in the account. Enter the name of the bank and the account number. If this is a joint account with two (2) or more names, list the other owners.	**Bank:** **Account No:** $	**Bank:** **Account No:** $	**Bank:** **Account No:** $
D. STOCKS OR BONDS — Enter the cash value (how much it is worth now) of the stocks and bonds each person owns. (Be sure to list any dividends in item "I" under Part V — Income.)	**Cash Value** $	**Cash Value** $	**Cash Value** $
E. TRUST FUND	$	$	$
F. LIFE INSURANCE AND ANNUITIES	**Insurance Co:** $ **(Cash Value)**	**Insurance Co:** $ **(Cash Value)**	**Insurance Co:** $ **(Cash Value)**
G. CERTIFICATES OF DEPOSIT/MUTUAL FUNDS	$	$	$
H. OTHER (identify)	$	$	$
TOTAL	$	$	$

READ CAREFULLY BEFORE SIGNING

- I understand I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services will use these statements to determine my eligibility for the AIDS/HIV Health Insurance Premium Payment (HIPP) program.
- I understand that I am to reimburse the Department for any money received by me or paid to a vendor on my behalf to which I was not entitled.
- I understand that as a condition of eligibility for this program, I may be required to apply for and accept Medicaid (Title 19).
- I understand that my eligibility for this program will cease if funding is exhausted.
- I understand I am required to report changes in my circumstances to the Department of Human Services within 10 days. These include, but are not limited to, changes in income, resources, employment, health insurance coverage, health insurance premium, and my address.
- I am aware that Iowa laws provide that anyone who obtains or tries to obtain or who helps any person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the State of Iowa, including Iowa Code Chapters 239, 249, and 249A.

SIGNATURES

All persons required to sign this application are signing under the penalty of perjury.

I CERTIFY THAT THE STATEMENTS I HAVE MADE ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature or Mark of the Applicant	Date
Signature of Person, if any, Who Helped Complete Form	Date
Witness to Mark of Applicant if Applicant Unable to Sign	Date

USE THE SPACE PROVIDED BELOW FOR ANY ADDITIONAL INFORMATION OR COMMENTS

POLICY ON NONDISCRIMINATION

This action was taken without regard to race, color, creed, sex, age, physical or mental disability, religion, national origin, or political belief. If you have reason to believe that you have been discriminated against for any of the reasons stated above, you may file a complaint with the Iowa Department of Human Services (DHS) by completing a Discrimination Complaint form. Any DHS office, Institution, or the DHS Bureau of Equal Opportunity can give you a form. You may also file a complaint with the Iowa Civil Rights Commission (if you feel you were treated differently **BECAUSE OF** your race, creed, color, national origin, sex, religion, or disability); or the United States Department of Health and Human Services, Office for Civil Rights.

IOWA DEPARTMENT OF HUMAN SERVICES
Bureau of Equal Opportunity
5th Fl Hoover State Office Bldg
Des Moines IA 50319-0114

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights Region VII
601 E 12th St Rm 248
Kansas City MO 64106

IOWA CIVIL RIGHTS COMMISSION
c/o Grimes State Office Building
221 E Maple St 2nd Fl
Des Moines IA 50319-0201

FOR OFFICE USE ONLY

Disposition of Application: Presumptively Approved Date: _____

Approved Date: _____

Denied Date: _____

Comments _____

_____

Signature of Worker