

EOHHS-Health Insurance Assistance Program (HIP) Enrollment Form

Application & Instructions

EOHHS- Health Insurance Premium Assistance Program (HIP)

EOHHS-Ryan White/ HIV Provision of Care
Hazard Building, Suite 60
74 West Road Cranston, RI 02920
401-462-3294

General Information

The RI Executive Office of Health & Human Service offers two programs to provide access to healthcare (ADAP, and RI-HIP) for Rhode Island residents with HIV infection who are uninsured or underinsured. The two programs initially use the same application form and enrollment process however, additional forms are required for EOHHS-Health Insurance Premium Assistance Program.

EOHHS-Health Insurance Premium Assistance Program

Pays for cost effective health insurance premiums for ADAP eligible participants with health insurance.

HIV Uninsured Care Programs Confidentiality Statement

Under Rhode Island State Law, HIV related information provided to us is kept strictly confidential. Such information (i.e. a program that you are a participant in) may be given to those parties necessary for the proper administration of the Programs. These are individuals and organizations with whom the Programs need to discuss your application and/or participation in order to determine eligibility, pay for services or drugs covered under the Programs, or properly account for the funds spent. Our program staff is aware of a participant's need for confidentiality and privacy, and will discuss personal information only as strictly necessary for the administration of the Programs.

To provide you with an understanding of the issue of confidentiality and the conditions of participation in the Programs, the following examples are provided:

- The Programs will **NOT** contact your employer, landlord, family, friends, neighbors, or anyone else without direct consent from you; whether directly related to your application or participation in the Programs.

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- The Programs could verify to a pharmacy, or to a health care provider that you are enrolled in a Qualified Health Plan.
- The Programs will discuss the application of individuals in prison with authorized employees of Parole or Corrections as needed to enroll in the Programs.
- The Program will mail you information in a non-identified envelope, but is not responsible if that envelope is opened by anyone other than the addressee (you). If you wish to receive mailings in a place other than your residence, you must speak with your case manager and/or a Program staff member.

You may notify the Programs, in writing, if there is someone you want the Programs to contact in the event Program staff cannot contact you for more information (i.e. the case manager and/or social worker who is helping you to apply for the program).

The Rhode Island Ryan White Program is the payer of last resort and may contact your health insurance company or other third party payer (i.e. drug manufacturer rebate program) who will reimburse ADAP for drugs provided to you under the Programs. This is necessary for ADAP to recover funds which can be used to expand the Program to cover new drugs/services and more people living with HIV infection.

These conditions are from the date of your application until your termination from the Programs, including the time needed to complete any third party reimbursement procedures for therapeutic drugs or services provided by the Programs. You may terminate your enrollment in the Programs in writing at any time.

If you have questions please call 1-401-462-3294.

ALL INFORMATION PROVIDED TO THE PROGRAMS IS KEPT STRICTLY CONFIDENTIAL.

Application Instructions

Eligibility is based on financial and medical need. Along with a current and completed ADAP application on file, documentation of Rhode Island residency, proof of income. In addition, clients must also supply necessary documentations from HealthSource RI including the application review page. Please work with your case manager.

Applications submitted with all required documentation are processed within two weeks. Incomplete applications and applications without supporting documentation will delay the process of your enrollment.

When you are approved, you will get a Health Insurance Card. Please forward a copy of your health insurance card to EOHHS ADAP/HIP Program within 30 days from receiving your new card. Show your card to participating health care providers to receive covered medical services. Please note that HIV medications that are currently on the RI ADAP formulary will continue to be covered through RI ADAP. You must present your ADAP identification card when you fill your HIV medications, along with your new health insurance card. The two cards must be presented along with a prescription at a participating pharmacy to receive covered medications at no charge. Your pharmacist will need this card to verify your eligibility for EOHHS Drug Assistance Program.

EOHHS Health Insurance Premium Assistance Program (HIP) Enrollment Form-RIFAB

The EOHHS Health Insurance Premium Assistance Program (HIP) is one of the services offered by the Rhode Island Ryan White Program. The purpose of the HIP program is to pay health insurance premiums on behalf of ADAP eligible participants.
If you have any questions about completing this application, please contact us at 401-462-3294.

Health Insurance Premium Assistance PROGRAM REQUIREMENTS:

- Must currently be enrolled in the Rhode Island ADAP Program, if you are not enrolled with ADAP, you must fill out the RI ADAP Application.
- You must meet all RI ADAP eligibility requirements: Rhode Island State residency (cannot be undocumented), and certain medical, and income criteria.
- You are paying for, or will need to pay for, your insurance premiums and cannot afford them.

TYPE OF INSURANCE POLICY COVERED:

- **DIRECT PAY** – Insurance policy purchased directly from the RI Health Exchange via HealthSource RI.

Please review the entire application and fill out completely or processing this application will be delayed.

A. YOUR INFORMATION:

Name:	
ADAP ID Number:	HSRI Client Account Number:
Mailing Address:	
Social Security Number: - -	
Date of Birth: / /	
Daytime Phone: () -	
Other Phone: () -	
(Person to speak on your behalf - Family Member, Friend, Social Worker)	

B. BACKGROUND INFORMATION:

1) Are you currently employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your employer provide insurance?
2) Is this an Individual or Family Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*If yes, you must include a copy of the most recent premium invoice showing amount currently due along with application review page. <input type="checkbox"/>
3) Is this an approved EOHHS insurance Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

C. INSURANCE COMPANY INFORMATION: Please obtain and send a copy of the front and back of your insurance cards when you receive it to EOHHS attention ADAP/HIP Program.

Insurance Company Name:	Effective Date on Policy: / /
	Policy Number (if known):
	Group Number (if known):

***Please note that a print out of the application review page (the account summary page) along with a print out of the plan that was selected with the monthly premium amount from HealthSource RI must be submitted with this application. Failure to submit that along with your application will delay your application from being processed.**

D. PAYMENT INFORMATION:

Type of Insurance Plan.

• For Direct Pay, Send us the most recent invoice showing the current balance due.

Insurance Company Name:	Contact Person: _____		
	Contact Phone:	()	
Insurance Company Address:	Payment is Due:	Monthly Other:	Quarterly
Premium Payment Amount: \$	Payment Due Date:	/ /	

I certify that the above information is true and accurate to the best of my knowledge and I understand the following:

- Program officials will verify the information on this form

I authorize the Rhode Island Executive Office of Health & Human Services (EOHHS), ADAP/HIP Program, to obtain any information from the individuals or companies I have indicated on this form regarding my private health insurance coverage, including information regarding payee address, covered benefits and the status of my policy which will be used to determine if the EOHHS will pay my Health Insurance Premiums. I hereby apply for benefits under the EOHHS Health Insurance Assistance Program and consent for my information to be used and disclosed as necessary for the purposes of my treatment, for payment of healthcare services, payment of healthcare premiums and for the healthcare operations of the Program.

I fully understand that by applying for this program, I am divulging personal information that will be used to assist The Executive Office of Health & Human Services in providing me with benefits associated with The RI Drug Assistance Program & The Health Insurance Premium Assistance Program. I understand this information will be kept confidential, (§23-6-17 Confidentiality, §23-6-18 Protection of Records), but will be used by staff to review my eligibility for this program. By applying for this program I fully understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met. In addition, I understand The Executive Office of Health & Human Services reserves the right to terminate benefits due to not meeting program requirements, such as incoming being above the 500% FPL, not recertifying every year during the open enrollment period, a lack of funds and/or fraudulent claims on behalf of an applicant. I also understand that this program is a payer of last resort, meaning that I must exhaust all other possible sources of payment for these services before applying for this program. Lastly, I understand that it is my responsibility to provide The Executive Office of Health & Human Services with truthful information and documentation about my financial, employment, insurance, and HIV status.

Reconciliation of Premium Tax Credits and Vigorous Pursuit of excess premium tax credits:

Policy Clarification Notice (PCN) #14-01 Revised 04/03/2015

It is possible that a client's actual premium tax credit calculated on the tax return is more than the client's APTC resulting in the client receiving excess premium tax credit either through a reduction in overall tax liability or a refund from the IRS.

Any individual enrolled in insurance through HSRI that was paid for by RI ADAP's Health Insurance Premium Assistance Program, is required to file a federal income tax return for that year, even if they don't owe taxes. The Advance Premium Tax Credit received at enrollment is an advanced payment that was based on their estimated household income for the year, but the final tax credit they are eligible for is based on their actual income for the year. The tax return is the place where the IRS will reconcile these two amounts to determine any amounts paid in excess of what an individual was eligible for, or vice versa.

Every year, all marketplace insurance clients should receive a **Form 1095-A** from HSRI. This form will indicate the amount of APTC paid to insurers on the consumer's behalf during the year. Information on this form will also be reported to the IRS.

Individuals who received insurance through HSRI will have to file a new form with their income tax return – **Form 8962**. Instructions for this form explain how to calculate the amount of their premium tax credit eligibility based on the income reported on their tax return, as well as any overpayment or underpayment that may have occurred.

Consumers who over-estimated their income and didn't receive all of the APTC they were eligible for can receive the remainder as a tax refund. **Keep in mind that since ADAP will be paying your monthly premium, any credit received for underpayment of tax credits is owed to the ADAP program and must be returned to have continued eligibility for our services.**

_____ Applicant Initials

I certify that the information provided in this application is true and correct as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application or immediate termination from the program and liability for money granted.

SIGN AND DATE THIS FORM:

Signature of Applicant (or legal guardian if unable to sign) _____
Date

Keep a copy of this form for your records and mail the original form and all documentation to:

**EOHHS
HIV Provision of Care
Hazard Building, Suite 60,
74 West Road, Cranston, RI 02920**

If you have questions or need more information please call us at 401-462-3294 between 8:00 AM and 3:00 PM Monday through Friday.



EOHHS Drug Assistance Program Mock MAGI Worksheet

Only for use with applicant's who have not filed a Tax Return for the most recent Tax Year

**ALL Fields MUST be completed, or form will be considered incomplete.
Supporting documentation required if applicable**

Name:	Number of Legal Dependents Included in totals: 3
Date of Birth / /	Did client file a Tax Return for the most recent Tax Year? (If yes, Tax Returns are required along with current income documents if applicable) <div style="display: flex; justify-content: space-around; align-items: center;"> Y / N </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <input type="checkbox"/> Check One <input type="checkbox"/> </div>
SS# - - <small>If you do not have a Social Security Number, enter 000-00-0000</small>	

Types listed in ALL CAPS are not calculated in MAGI, but are required

For any income losses, enter negative \$ amount

Income Sources - Total Monthly \$ Amount for all Legal Household Members - * Supporting documentation required

Wages, Salaries, tips, etc.	*	Pensions & Annuities (Veteran or Employer Based Pensions, Retirements, or Disability)	*
Taxable Interest	0	Rental real estate, partnerships, S Corporations, Trusts, ect.	0
Tax Exempt Interest	0	Farm income or loss	0
Ordinary Dividends	0	Unemployment Income	* \$
Taxable refund of State/Local Income Taxes	0	Retirement Income from Social Security (SSA)	
Alimony/other Spousal Support Received	*	Disability Income from Social Security (SSDI)	*
Business Income/Loss	0	SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)	Specialty Line A 0
Capital Gain/Loss	0	Other income (Jury Duty, Gambling Winnings)	*
Other Gains/Losses	0	CHILD SUPPORT RECEIVED, WORKERS COMP, MONETARY GIFTS	Specialty Line B 0
IRA Distributions - Taxable amount	0		
Total Column 1	\$	Total Column 2	\$
Total Income		\$	(Total #1 + Total #2)

Non MAGI (Not calculated but, required) - Total Monthly \$ Amount for all Legal Household Members

Educator Expenses	0	Penalty on Early Withdrawal of Savings	0
Business Expenses	0	Alimony Paid	0
Health Savings Account	0	IRA deduction	0
Moving Expenses	0	Student Loan Interest Deduction	\$
Deductible Part of Self Employment Tax	0	Tuition and Fees	0
Self Employed SEP, SIMPLE plans	0	Domestic Production Activities	0
Self Employed Health Insurance Deduction	0		
Total Column 3	\$	Total Column 4	\$
Total Non MAGI		\$	(Total #3 + Total #4)
Add Specialty Line A	+	\$ 0	(SSI)
Add Specialty Line B	+	\$ 0	(Child Supp, Work Comp, etc.)
NON MAGI SUBTOTAL		\$ 0	Total Non MAGI + Spec Line A + Spec Line B

\$	-	\$	=	\$
Total Income	minus	Non MAGI Subtotal	equals	FINAL MAGI

Notes

Client Signature

Date

Revised
10/09/14 PPB

Date: _____

To: EOHHS/Phanida

I, _____, am writing to ask for your assistance with paying
(medical case manager's)

_____ 's (Date of Birth: _____)
(patient's name)

premiums for coverage under the Affordable Care Act/Health Source RI.

I am writing this letter to verify that he/she:

is not offered any insurance through his/her employer

is not able to afford the insurance offered through his/her

Employer due to _____

does not qualify for Medicaid due to immigration status/
residency requirement being 5 years or less

Other _____

Please accept this letter as proof of eligibility/need and consider him/her for your financial assistance with EOHHS Premium Insurance Assistance Program-RIFAB.

Thank you,

Medical Case Manager