

OA-HIPP CHECKLIST

The Office of AIDS Health Insurance Premium Payment (OA-HIPP) program will pay private health insurance premiums for individuals that meet the following requirements:

- Must be a California resident;
- Must be at least 18 years old;
- Must have an HIV/AIDS diagnosis;
- Must have an adjusted gross income not to exceed \$50,000; and
- Must not be enrolled in Medicare, Medi-Cal or Low Income Health Plan.

If you meet the program requirements and would like to enroll in OA-HIPP, please complete the following forms that apply completely and accurately. Applications will not be processed until all forms and documentation are provided.

Determine ADAP co-enrollment status	With ADAP		Without ADAP	
	Enroll	Recert	Enroll	Recert
Determine if this is the OA-HIPP initial/annual enrollment or recertification				
1. OA-HIPP Application	x	x	x	x
ID Verification, submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, Photo identification document issued by a foreign government, or Immigration Card. If no other form of photo ID - Birth Certificate or letter from the treating clinician certifying identity.			x	
California Residency Verification, submit a copy of one of the following: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, or Support Verification Form			x	
Health Insurance Verification: Insurance Estimate Letter, or Billing Statement (which includes Payee name, Federal Tax ID Number, premium payment address, monthly insurance premium, and effective dates), and documentation confirming prescription drug coverage (one-time) (If dental and vision coverage is through a different payee submit another OA-HIPP application to include dental and vision payee information)	x	x	x	x
HIV/AIDS Diagnosis Verification, submit one of the following: Diagnosis Form, clinic specific letter of diagnosis, or Lab results with HIV/AIDS Diagnosis			x	
Income Verification, submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub*, Bank Statement* (must clearly state income source), Benefit Receipt* or Check Stub*, Disability Award letter, Support Verification Form, or Self-Employment Form *3 current consecutive months			x	
Public Assistance Screening Form and supporting documentation			x	
2. Consent Form	x		x	
3. Client Report Form	x		x	

Please submit the completed forms and supporting documentation to:

Insurance Assistance Section
 California Department of Public Health
 P.O. Box 997426, MS 7704
 Sacramento, CA 95899-7426

Or fax to (916) 449-5860