



## PARTIAL PAYMENT AGREEMENT OA-HIPP PROGRAM



**The following information is required for applicants whose health insurance premiums exceed the OA-HIPP Program payment limits.**

### I. Applicant Information

Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number (Home)		Telephone Number (Alternate)		

### II. Current Insurance Plan Information (must attach a copy of your member ID card and billing statement)

Payee Name	Payee Contact Name	Payee Telephone Number	
Payee Address (Number, Street, or P.O. Box)	City	State	Zip Code
Payee's Federal Tax ID Number	Member ID/Policy Number	Monthly Premium Amount \$	
Monthly Program Threshold \$	Monthly Amount Due \$		

Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS (OA). The information may be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact the CDPH, OA-HIPP Program, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (844) 421-7050.

- I understand that I am an applicant with a monthly health insurance premium that exceeds the OA-HIPP Program limit and that I am financially responsible to pay the difference between the monthly premium amount and the program threshold.
- I understand that prior to sending payment, I must send a copy of this form to A.J. Boggs at the following address: 4660 S. Hagadorn Rd. Suite 290, East Lansing, MI 48823 or fax to (517) 481-3739.
- I understand that I must submit a cashier's check or money order to CDPH Pool Administrators Inc. (PAI) at the following address: 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033, made payable to the Payee Name listed above, for the difference owed between the monthly premium amount and the program threshold. I will submit subsequent payments each month and understand that payments will be due by the 1<sup>st</sup> of each month. In the event that the premium amount increases, I will notify A.J. Boggs and submit a new billing statement and Partial Payment Agreement form that reflects the new premium amount.
- I understand that PAI will not make an insurance premium payment on my behalf until my portion of the premium is received. I understand I will be terminated from the OA-HIPP Program and I will no longer be eligible to receive OA-HIPP services if I fail to pay the portion of the premium that I am responsible for.



## PARTIAL PAYMENT AGREEMENT OA-HIPP PROGRAM



*By signing this form, I hereby certify that the above information is factual, accurate, and complete. I agree to immediately notify ADAP of any changes in my insurance premium. I understand that failure to provide accurate information or deliberately omit information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.*

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date