

RYAN WHITE PROGRAM CARE/HIPP CLIENT DISCLOSURE

The following statements of policy and eligibility criteria apply to **all applicants**. **Please read and initial each statement.** Any questions should be referred to your Benefits Counselor before signing this document. The original of this document must be maintained in the client's file.

ELIGIBILITY

To be eligible to apply for CARE/HIPP, the client must demonstrate:

- Assets that do not exceed \$6,000.
- Application to Medi-Cal or proof of financial ineligibility for Medi-Cal based on proven excess assets.
- HIV-related disability, or is an adult dependent with HIV-related disability covered by health insurance of another person.
- Coverage under a health insurance policy that is at risk of cancellation.
- Eligibility to continue health insurance under COBRA or equivalent insurance coverage (private policy).
- Policyholder must be unable to work full time or employed part time for reasons related to HIV.
- Income at or below 400 percent of the current federal poverty level.
- Health insurance coverage of outpatient prescription drugs and does not exclude HIV treatment.
- Proof of application for public or private disability benefits.
- Proof of appeal of any denial of public benefits or be in the process of appeal.
- No previous denials for services specific to HIV disease.

GENERAL POLICIES

- No deductible or co-pay will be paid through this program.
- If either policy or coverage is changed, client must immediately notify Benefits Counselor.
- CARE/HIPP will not pay for the State's Major Risk Medical Insurance Program.
- Applicant cannot be receiving assistance through the AIDS Drug Assistance Program for medications that can be covered through a health insurance policy.
- Dependents may maintain coverage after death or departure from the program of the primary beneficiary for the balance of the quarter or one month, whichever is longer.
- Applicant must apply for Medi-Cal if and when assets do not exceed \$2,000.
- All refunds of premiums that were paid by the state on behalf of the applicant must be signed over to the State of California. (Refund checks should be made payable to California Department of Public Health (CDPH), and should be identified with the insured's full name, the policy number or Social Security Number, and the months to which the refund should be credited.)

IMPORTANT: Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2006 and is required by CDPH CARE/HIPP Unit. The information may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Furnishing the information on this form is mandatory. Failure to provide the mandatory information may result in benefit enrollment elections not being processed or being processed incorrectly. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH CARE/HIPP Unit, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, (916) 449-5900.

DECLARATION: In signing, I declare that I meet all eligibility requirements and that I have thoroughly read the provisions of this program and understand them. I understand that my health insurance premiums may be paid as long as I am eligible, until I enroll in the Medi-Cal HIPP program, become eligible for Medicare, or up to 36 months, whichever comes first. I agree to **immediately** notify the Benefits Counselor of any changes in my circumstances which affect program eligibility or health insurance status.

AUTHORIZATION TO OBTAIN INFORMATION: "I hereby authorize _____ and CDPH to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made on my behalf, which may be used to determine if the Department will pay health insurance premiums for continued coverage."

Signature of Client

Date

Signature of Policyholder (if different)

Date