



RYAN WHITE PROGRAM CARE/HIPP QUARTERLY RECERTIFICATION



1. NAME OF CLIENT- Last	First	Middle Initial	2. SOCIAL SECURITY NUMBER	3. MOTHER'S MAIDEN NAME
4. CLIENT'S ADDRESS - Number/Street		5. CITY AND COUNTY		6. STATE
				7. ZIP CODE
8. NAME OF POLICYHOLDER AND SOCIAL SECURITY NUMBER - If Different				9. CLIENT'S TELEPHONE NUMBER ()
10. POLICY NUMBER: Premium IS or WAS Due On: _____ Grace Period Ends: _____			11. PREMIUM AMOUNT \$ _____ (monthly)	

12. PAYEE INFORMATION		TELEPHONE NUMBER ()		CONTACT PERSON	
MAKE PAYMENT TO					
ADDRESS - Number/Street	City	State	Zip Code	PAYEE'S FEDERAL TAX ID NUMBER	

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 the California Department of Public Health (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 am not enrolled in the AIDS Drug Assistance Program to obtain outpatient prescription drugs that can be covered by private health insurance.

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 California Department of Public Health will pay health insurance premiums for continued coverage."

Signature of Client

Date

Signature of Policyholder (if different)

Date

BENEFITS COUNSELOR AGENCY USE ONLY

DECLARATION: I am certified to enroll and recertify clients in the CARE/HIPP Program and I certify that all eligibility requirements have been verified and met.

ORGANIZATION NAME	BENEFITS COUNSELOR NAME	TELEPHONE NUMBER
ADDRESS - Number/Street	CITY AND ZIP CODE	FAX NUMBER

ANNUAL RECERTIFICATION REQUIRED ON 4TH		ANNUAL RECERTIFICATION REQUIRED ON 8TH	
Recert 4 _____	Date _____	Recert 8 _____	Date _____
Recert 5 _____	Date _____	Recert 9 _____	Date _____
Recert 6 _____	Date _____	Recert 10 _____	Date _____
Recert 7 _____	Date _____	Recert 11 _____	Date _____

STATE OF CALIFORNIA USE ONLY	
Amount to be paid \$ _____	Effective _____ to _____
CARE/HIPP Liaison _____	
The CDPH CARE/HIPP Unit authorizes the above payment(s) in the amount, for the period, and to payee indicated above.	
_____ AUTHORIZED SIGNATURE	_____ DATE

**RYAN WHITE PROGRAM
CARE/HIPP
QUARTERLY RECERTIFICATION
INSTRUCTIONS**

The Quarterly Recertification form must be completed at recertification number four (4). CARE/HIPP clients must submit new and/or updated eligibility documentation annually at recertification numbers four (4) and eight (8).

1. **Name of Client** - Enter the name of the individual who wants to apply for CARE/HIPP assistance.
2. **Client's Social Security Number** - Enter the Social Security Number of the individual who wants to apply for CARE/HIPP. **NOTE:** This information is required as it is used to assist the CARE/HIPP Liaison in identifying and tracking the premium payments.
3. **Client's Mother's Maiden Name** - Enter the Mother's Maiden Name of the individual who wants to apply for CARE/HIPP.
- 4-7. **Client's Address** - Enter the address (number/street), city and county, state, and ZIP code where information regarding CARE/HIPP will be mailed.
8. **Name of Policyholder and Social Security Number (If Different)** - If the CARE/HIPP client is covered under the policy of another individual, please specify the name of the policyholder and his/her Social Security Number.
9. **Client's Telephone Number (Including Area Code)** - Please enter the daytime telephone number where the CARE/HIPP client can be reached.
10. **Policy Number** – Enter the number used by the payee to identify the policy or policyholder, whichever is applicable. Enter the date the premium is/was due and the date the grace period ends.
11. **Monthly Premium Amount** - Enter the total amount of the monthly premium.
12. **Payee Information** - Enter the name, mailing address, telephone number (including area code) of the payee or policyholder, whichever is applicable. Enter the federal tax ID number required by the California Department of Public Health, Accounting Section.

IMPORTANT: Carefully review the information in the boxes prior to signing the completed application.

DECLARATION: The Declaration indicates that all eligibility requirements have been met.

AUTHORIZATION TO OBTAIN INFORMATION: Enter the name of the agency your Benefits Counselor represents on the blank line. This authorizes the Benefits Counselor to help you obtain information necessary for the submission of this application and the California Department of Public Health to confirm information received.

SIGNATURES - Both the CARE/HIPP client and policyholder are required to sign and date the application. If the client is the policyholder, sign on the second line only. If the client and policyholder are different, both lines must be signed.

BENEFITS COUNSELOR AGENCY USE ONLY - Stop Here - Once you have come to this part of the application, return it to the Benefits Counselor with the required eligibility documents.