

YOUR RIGHTS AND RESPONSIBILITIES

When you apply for assistance with Louisiana's Health Insurance Premium Payment (LaHIPP) Program, you agree to the following:

- I will cooperate in giving LaHIPP information about health insurance from my job and I will enroll in this insurance. I will also enroll dependents who get Medicaid if LaHIPP decides it is cost-effective to help pay for the insurance.
- I will continue to keep group health insurance from my job as long as I get LaHIPP premium payments.
- If I decide that the requirements to enroll or stay enrolled in group health insurance cause me a hardship, I will contact the LaHIPP program and ask for a review of my situation.
- I agree that LaHIPP can contact any person, medical provider, insurance company, employer, or other organization/agency to get information about health insurance, medical treatment and employment for me and/or my dependents.
- I agree to tell LaHIPP within 10 days about:
 - Changes in what the health insurance covers
 - Changes in the cost of the insurance
 - When a pregnancy ends
 - When Medicare becomes available
 - Changes in the insurance company
 - If a job ends
 - If anyone moves out of state
- I agree that if I get money from LaHIPP for my insurance that I should not have received, I will have to pay the money back to the Louisiana Department of Health.
- I agree that LaHIPP can use the Division of Administration's (DOA) LaGov electronic system to make payments to me for my health insurance premiums and that LaHIPP can give DOA and my bank any information that they need in order to make those payments. I agree to register with the LaGov system or to allow LaHIPP to act on my behalf to register me, and I consent to all of the applicable terms and conditions for the use of the LaGov Supplier Self Registration Portal. If I wish to receive payments through electronic funds transfers (EFTs) instead of paper checks, I agree to submit an EFT enrollment form that has been filled out by me and my bank.

Your Rights

- LDH cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to the Louisiana Department of Health, Human Resources at P. O. Box 4818, Baton Rouge, LA 70821-4818.

Read and sign below

By signing this application I am giving my permission to the State of Louisiana and its agents to verify the information given on this application. Under penalty of perjury, I certify that all information is true and correct to the best of my knowledge. I have read or someone has read to me the "Rights and Responsibilities" section of the application.

Sign here:

Date:

