LOUISIANA DEPARTMENT OF HEALTH
Medicaid

The Louisiana Health Insurance Premium Payment Program
LaHIPP

APPLICATION FOR THE LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Medicaid Assistance with Paying Insurance Premiums

- Fill out this application to see if you qualify for the Louisiana Health Insurance Premium Payment (LaHIPP) Program. LaHIPP may help pay some or all of the health insurance premiums to the policy holder if someone in the family is eligible for private health insurance through a job or an individual plan and has Medicaid.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-855-618-5488** Monday–Friday between 8:00 AM–4:30 PM to speak with a LaHIPP representative, or visit us online at our website **http://ldh.la.gov/lahipp**.
- Complete and mail this application to **LaHIPP, 7389 Florida Blvd. Suite 400, Baton Rouge, LA 70806** or fax it to **1-855-618-5486**. You can also e-mail a copy of this application to **La.HIPP@la.gov**.

How did you hear about LaHIPP? _____

What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

► *Please **PRINT** clearly in black ink.*

1 — Personal Information

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

2 — Contact Information

Mailing Address			Home Address *(if different)*		
P.O. box or street address		Apt/Lot #	Street address		Apt/Lot #
City	State	Zip	City	State	Zip
E-mail address			Home parish *(where you live)*		

Cell phone	Home phone	Other phone

3 — Members of your Household

*List **ALL** people living in your home. If no one lives with you, leave this section blank and skip to section 4.*

	Person 1	Person 2	Person 3
Name			
Relationship to you			
Social Security number			
Date of birth			
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Is this person enrolled in a private health insurance plan?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, is this health plan court ordered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, what is the name of the birthing center? *(if applicable)*			

4 — Health Insurance *(other than Medicaid)*

Name of policyholder	Policyholder phone number	
Mailing address of policyholder *(if they do not live in your home)*		
Insurance company name		
Insurance company address		
Insurance company phone	Policy number	Group number
Is this an employee-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ ESI ☐ IHI		
Policy premium *(if known)* $	How often is the premium paid/deducted? ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly ☐ Other:_____	

Please provide a front and back copy of the health insurance card for this policy for verification

5 — Payment Registration

*To receive LaHIPP payments, you **MUST** register with the Division of Administration's (DOA) LaGov system. To register with the LaGov system, download and complete the **W-9 Form** from the website below.*
http://ldh.la.gov/lahipp

Do you or anyone in your household have a bank account that can be used for electronic deposits? ☐ Yes ☐ No

*If you wish to receive payments through electronic funds transfers (EFTs) instead of paper checks, visit the website below and download the **EFT Enrollment Form** from that page. Have your bank or financial institution assist you with completing this form.*
http://ldh.la.gov/lahipp

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 my current health insurance coverage and enroll if required. 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 private health insurance coverage as long as I get LaHIPP premium payments.
- If I decide that the requirements to enroll or stay enrolled in private health insurance cause me a hardship, I will contact the LaHIPP program and ask for a review of my situation.
- I agree that LaHIPP may 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:

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Health Insurance Information Form

- This form **MUST** be completed by the entity providing health insurance to the LaHIPP applicant, in order to make a final determination of eligibility for health insurance premium reimbursement. Although some information may not relate to the applicant or they may not currently have health insurance, this information is still needed.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-855-618-5488** Monday–Friday between 8:00 AM–4:30 PM to speak with a LaHIPP representative, or visit us online at our website **http://ldh.la.gov/lahipp**.
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1 — Provider Information	
Provider name	Provider phone number
Provider address	

2 — Carrier Information	
Insurance carrier name	Insurance carrier phone number
Insurance carrier address	Insurance carrier fax number *(if applicable)*
Are multiple plans offered by this insurance carrier? ☐ Yes ☐ No *(Please submit a summary of benefits for all plans with this form)*	
Is there an Open/Annual Enrollment Period? ☐ Yes ☐ No	If **NO**, when would changes to insurance go into effect?
If **YES**, what are the dates for this period? Begin date: End date:	When would changes to insurance go into effect for this period?

3 — Insurance Coverage Information

What coverage is provided by the insurance carrier? *(Check all that apply)*

☐ Major Medical ☐ Health Savings Account ☐ Health Reimbursement Account

☐ High Deductible — Amount: _____ ☐ Other: _____

Tell us your policy holder's share of monthly premiums. If any standard tiers are not applicable, please indicate with N/A)

Standard Tiers	Monthly Premium Share *(without wellness credit)*	Plan Deductible Amount
Policy Holder Only	$	$
Policy Holder and Children	$	$
Policy Holder and Spouse	$	$
Family	$	$

How frequent are premiums paid?

☐ Weekly (**48** times a year) ☐ Weekly (**52** times a year) ☐ Biweekly (**24** times a year) ☐ Biweekly (**26** times a year)

☐ Monthly ☐ Semi-Monthly ☐ Annually ☐ Other: _____

4 — Applicant Information (Private Insurance)

Is the LaHIPP applicant actively receiving coverage from an employee-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ Yes ☐ No *(if **NO**, skip to section 5)*

Provide the following information for the policy holder.

First name | Middle initial | Last name | Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

Insurance policy number	Insurance group number

Is this an employee-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ ESI ☐ IHI

Is the first month's premium due before coverage becomes effective? ☐ Yes ☐ No

Can changes be made to this coverage by the policy holder at times other than open/annual enrollment? ☐ Yes ☐ No

Provide the following information for all dependants of the policy holder who are enrolled or have been enrolled in their health insurance plan. Include information for the policy holder.

Name	Social Security Number	Date of Birth	Date Added to Insurance	Insurance End Date

5 — Applicant Information (COBRA)

Is the LaHIPP applicant actively receiving COBRA coverage? ☐ Yes ☐ No *(if **NO**, skip to section 6)*

Provide the following information for the COBRA policy holder.

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

When did COBRA coverage begin?	What was the name of their COBRA contact?

COBRA phone number	COBRA fax number *(if applicable)*

Provide the following information for all dependants of the COBRA policy holder who are enrolled or have been enrolled in a COBRA health insurance plan.

Name	Social Security Number	Date of Birth	Date Added to Insurance	Insurance End Date

6 — Form Filer Information and Signature

Name of representative completing form		

Representative mailing address		

Representative phone number	Representative fax number *(if applicable)*	Representative e-mail address

Sign here:	Date:

Thank you for your time in assisting Medicaid and LaHIPP!

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