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 policyholder 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 **Attn: LaHIPP, P. O. Box 91030, Baton Rouge, LA 70821-0930** 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 employer-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

- By signing and submitting this application, you state that you have permission from all of the people listed on the application to both submit their information to the Louisiana Department of Health (LDH), and receive any information about their eligibility and health coverage.
- You understand that LDH is authorized to gather the information requested in this application and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.
- You understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent you from getting health coverage through Medicaid or any other insurance affordability program.
- You understand that LDH will check the information you give us to make sure it is correct. You give LDH permission to contact any outside source(s) necessary to check this information, process your application, determine eligibility, and otherwise operate the Medicaid program. These outside sources may include:
  - Federal agencies (such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security), other state agencies, and/or local government agencies.
  - Banks, financial institutions, and consumer reporting agencies.
  - Employers identified on applications for eligibility determinations.
  - Doctors or other medical providers.
  - Applicants/enrollees, and authorized representatives of applicants/enrollees.
  - LDH contractors engaged to perform a function for the Medicaid program.
  - Anyone else as required or allowed by law.
- You give these outside sources permission to give LDH any information about you, or any person necessary for this application, that it may request. You understand that this permission will end when this application is denied, when your Medicaid eligibility ends, or when you submit a written statement to LDH canceling this permission, whichever comes first. A cancellation may prevent you from being found to be eligible for Medicaid.
- You understand the social security numbers will only be used to get information from these outside sources to verify income, make eligibility determinations, or for other purposes directly connected to the administration of the Medicaid program.
- You must tell Medicaid if anything changes or is different than what you've written on this application. Call 1-888-342-6207 to report any changes. You also understand that a change in your information could affect the eligibility for member(s) of your household. You agree to tell Medicaid within 10 days if any of the following change: mailing or home addresses, things you own, health insurance coverage or premiums, income, if anyone moves in or out of your home, or if anyone moves out of state.
- You state that answers you gave on this application are true and correct. If you purposely gave information that is not true or if you withheld information, you have committed fraud. If you commit fraud, you may have to pay back money that Medicaid pays for care that you receive.
- You state that the information given in this application about your citizenship and immigration status is true and correct.
- By signing and submitting this application, you understand that if anyone on this application enrolls in Medicaid, you are giving LDH your rights to any money owed to you by any other health insurance, legal settlement, a spouse or parent, or other third party.
- You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to. LDH will only make a referral if parents of children under age 19 receive Medicaid. You can request that Medicaid not refer you if you feel you have good cause not to cooperate with Child Support Enforcement.
- You understand that Estate Recovery rules require LDH to recover the cost of certain Medicaid payments from your estate in the event of your death. These costs include the total amount of payments for facility services, hospital care, waiver services, payments to Home and Community Based Services (HCBS) or Program for All-Inclusive Care for the Elderly (PACE) providers, and prescription drugs received at age 55 or older. LDH will not make a claim against the estate while you or your legal spouse is still living. LDH will also not make a claim if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for LDH to do so, or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or if there are other extenuating circumstances.
- You agree that by accepting Medicaid, the State of Louisiana or its assignee will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on your behalf, unless you have a spouse, minor child, or a child with a disability. In these cases, the State of Louisiana must be named as beneficiary after these individuals. You agree to tell Medicaid about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. You understand that you must tell Medicaid about changes made to any annuity which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.
- You can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
- 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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THE LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

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**.
- Complete and mail this form to **Attn: LaHIPP, P. O. Box 91030, Baton Rouge, LA 70821-0930** or fax it to **1-855-618-5486**. You can also e-mail a copy of this form to **La.HIPP@la.gov**.

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

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 policyholder'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
Policyholder Only	$	$
Policyholder and Children	$	$
Policyholder 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 employer-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ Yes ☐ No *(if **NO**, skip to section 5)*

Provide the following information for the policyholder.

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 employer-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 policyholder at times other than open/annual enrollment? ☐ Yes ☐ No

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

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 policyholder.

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 policyholder 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!

The Louisiana Health Insurance Premium Payment Program

LaHIPP