41 Crossroads Plaza #110
West Hartford, CT 06117

Client name
Address Line1
City, State Zip code

Date

Dear Client,

We are sending you information about the Connecticut Insurance Premium Assistance (CIPA), a program that helps eligible individuals with the cost of health insurance premiums. Eligibility requirements include but are not limited to individuals that are eligible for the Connecticut AIDS Drug Assistance Program; that is, you must be a Connecticut resident, have an HIV/AIDS diagnosis, and a total income that is less than or equal to 400% of the federal poverty line, which is $48,560 per year for one person. Some deductions can be applied toward your gross income. To apply for the CIPA program, please fill out the attached program application. We ask that you please follow all instructions and return the completed application within 10 days to the address above or fax it to 1-855-888-3300.

If you are determined to be eligible for this program, CIPA will pay your health insurance premiums directly to your employer (upon employer approval of third party payment), or to your COBRA administrator or private health insurance administrator directly, effective **the month after we receive all necessary information**. CIPA cannot reimburse individuals directly for health insurance premium payments. We encourage you to supply all the information to CIPA as soon as possible, so that CIPA can immediately begin the review of your application. If you have any questions, please contact the CIPA program at our toll-free phone number 1-855-888-CIPA (2472).

Please note that CIPA is not able to pay for family coverage, only individual coverage, and will only pay up to a maximum of $1,500 per month toward approved health insurance premiums. Dental insurance is not covered by CIPA unless it is included in the medical insurance plan and cannot be "broken out."

Thank you for your interest in the CIPA program.

Sincerely,

The Connecticut Insurance Premium Assistance Team

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APPLICATION FOR CONNECTICUT INSURANCE PREMIUM ASSISTANCE (CIPA)

SECTION I – APPLICANT'S NAME AND ADDRESS

Name_____ Date_____
(First) (MI) (Last)

Address_____
(Street) (Box or Apt. #)

City/State/Zip _____

Phone with area code _____

SECTION II – APPLICANT'S INSURANCE INFORMATION

1a. Do you or anyone in your family have health insurance or applied for health insurance? ❑ YES ❑ NO

b. If YES, which type: ❑ SELF PURCHASED ❑ EMPLOYER ❑ COBRA

c. If yes, check the box(es) next to all prescription types below that your health insurance covers:

❑ Prenatal Vitamins	❑ Antibiotics	❑ HIV/ AIDS-related	❑ Birth Control	

Please add others if necessary: _____

2. Mail Order Pharmacy Benefits

a. How do you obtain your prescription drugs? ❑ Retail Pharmacy ❑ Mail Order Pharmacy

b. If you use a Mail Order Pharmacy, is it: ❑ Mandatory ❑ Optional

❑ **I understand that if I obtain my prescriptions from a Mail Order Pharmacy which is not an enrolled Connecticut Medicaid provider, CIPA will not be able to approve my application.**

3. Type of health coverage: ❑ Individual ❑ Individual and child ❑ Individual and Spouse ❑ Family

Please note: CIPA is not able to pay for family coverage, only individual coverage.

4. What is the premium for this policy (if known)? $_____ These premiums are paid/deducted:

❑ Weekly	❑ Every other week	❑ Twice Monthly	❑ Monthly	❑ Quarterly	❑ Other

Please note: CIPA will pay up to a maximum of $1,500 per month towards your health insurance premium if approved.

5a. If you have health insurance please complete this section with the policy holder's information.

Name of Policy Holder: _____
(First) (MI) (Last)

Social Security Number :_____ Date of Birth _____

Address: _____

City/ State/ Zip: _____

Home Phone:_____ Cell Phone:_____ Email : _____

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❑ **Yes, it is okay to send important information about CIPA to my email address or home address provided above.**
(If Yes, check the appropriate box below.)

_____Send to my email address _____Send to my home address

Insurance Company _____

Policy Number (Mandatory):_____Group Number: _____

Effective Date of Policy:_____End Date:_____Other: _____

5b. If you have Employer Sponsored Insurance, please fill out the attached authorization form to give us permission to contact your employer requesting verification of employment, insurance premium cost, and acceptance of third party payments.

If you do <u>not</u> want us to contact your employer, please check here _____

Please note: If you have employer sponsored insurance and you are not willing to grant CIPA the authorization to contact your employer in all confidentiality regarding your health insurance, your application will <u>not</u> be processed.

6. List all persons covered by the policy. (Use extra paper if you need to.)

Name	Social Security Number	Birth Date	CADAP ID Number	Relationship to Policyholder	Gender
		/ /			
		/ /			
		/ /			
		/ /			

Please note: CIPA will only pay the health insurance premium for the individual, not spouse or family.

<u>SECTION III – APPLICANT'S CONSENT TO RELEASE PROTECTED MEDICAL INFORMATION TO DSS</u>

7. Consent Agreement: This information is being disclosed to CIPA from records whose confidentiality is protected by state law. State law prohibits CIPA from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature:_____Date: _____

Please contact our office if you have any questions about our application.

For faster processing attach a copy of the front and back of your **insurance card** if you have one, **employer rate sheet, summary of benefits** that indicate portion of premiums that cover CADAP client(s), and a recent **pay stub or other verification** to show your premium payment. If you have any questions, call 1-855-888-CIPA(2472).

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SECTION V – APPLICANT'S CONSENT TO ALLOW DSS TO RELEASE PROTECTED HEALTH INFORMATION TO HMS

I hereby authorize Health Management Systems, Inc. (HMS), a contractor of the Department of Social Services (Department), to use and disclose records in its possession including those records **that have confidential HIV - related information, as specified in the Connecticut General Statues Section 19a-585,** indicating that _____, a Connecticut Insurance Premium Assistance (CIPA) Program
(Print Applicant's/Client's Name)
applicant or client, has human immunodeficiency virus (HIV) infection, HIV-related illness or acquired immune deficiency syndrome (AIDS) to Department employees and agents, health insurers and auditors, for purposes associated with the administration of CIPA and the other programs administered by the Department.
This authorization is valid for the duration of any functions related to the operation of CIPA and the other Department programs.

_____ _____or
Date Signed Signature of CIPA applicant or client

_____ _____or
Date Signed Signature of legal guardian of the CIPA applicant or client

_____ _____
Date Signed Signature of person authorized to consent to health care for the CIPA applicant or client

SECTION IV – APPLICANT'S CONSENT TO ALLOW DSS OR HMS TO RELEASE INFORMATION TO EMPLOYER

I give permission to HMS or the Department to communicate with the following individuals [employer sponsored health insurance] (if any) about my application and my benefits under the CIPA Program:

Employer Name (Print): _____

Address: _____

Telephone: _____ Email address _____

I understand this application and affirm that the answers given are true to the best of my knowledge.

I understand that the information on this application is subject to verification by the State. I may be subject to penalties for false statement as specified in the Connecticut General Statutes Section 53a-157b and 17b-97 and to penalties for larceny as specified in Section 53a-122, 53a-123 and 53a-124. I also may be subject to penalties for perjury under Federal Law.

_____ _____
Date Signed Signature of Applicant or Client

_____ _____
Date Signed Signature of Authorized Representative

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Your Right to Make a Discrimination Complaint: Under federal and state law you have the right to make a discrimination complaint if you think we have taken actions against you because of your race, color, religious creed, sex, age, marital status, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, learning disability or physical disability, including but not limited to blindness. You or someone representing you can write or call one or more of these agencies to make a discrimination complaint: **Commissioner of the Department of Social Services, Attention Affirmative Action Division Director/ADA Coordinator, 25 Sigourney Street, Hartford, CT 06106-5033,** or call 1-860-424-5040 (TDD: 1-800-842-4524);**Connecticut Commission on Human Rights and Opportunities, 999 Asylum Avenue, 2nd Floor, Hartford, CT 06105** or call 860-566-7710; (TDD: 1-860-541-3459); **US Department of Health and Human Services, Director, Office of Civil Rights, Region 1, JFK Federal Building, Room 1875, Boston, MA. 02203,** or call 1-617-565-1340 (TDD: 1-617-565-1343).