

**INSURANCE ASSISTANCE PROGRAM AND
INSURANCE ASSISTANCE PROGRAM-PLUS
APPLICATION**

Michigan Department of Human Services

Dear Applicant:

Thank you for your interest in the Insurance Assistance Program (IAP) and the Insurance Assistance Program-Plus (IAP-PLUS) programs. Both programs were developed to assist individuals to maintain and continue their health insurance benefits while facing financial difficulty due to their specific illness. The IAP and the IAP-Plus programs pay health insurance premiums for eligible individuals.

I. QUALIFICATIONS FOR THE IAP PROGRAM

To be eligible you must have private health insurance with no pre-existing condition clause. All medical services other than emergencies must be provided in Michigan. The requirements are:

- 1) *You Must Be HIV + and Must be Currently Too Ill To Work In Your Current Job, or There Is A Substantial Likelihood You Will Be Too Ill To Work Within The Next Three Months, As Verified by a Physician or Nurse Practitioner or client must be receiving SSDI or SSI..*
- 2) *Must Be A Michigan Resident.*
- 3) *Gross Monthly Income Must Be Less Than or Equal To 200% of The Federal Poverty Level (FPL). Proof of Your Income Is Required. If Your Income Is Above 200% of FPL, But Less Than 450% You Will Be Evaluated For The IAP Plus Program.*
- 4) *You Must Not Have More Than \$10,000.00 In Cash Assets.*
- 5) *You Must Not Be Eligible For Any Employer Sponsored Health Insurance, other than Your Current Policy.*
- 6) *You may be eligible for Medicaid*

All Recipients Approved For The IAP Program Will Be Required To Submit Updated Income, Asset, And Insurance Information At Least One A Year Or As Soon As A Change Occurs.

Any change in Insurance Status must be reported immediately.

II. QUALIFICATIONS FOR THE IAP-PLUS PROGRAM

To be eligible you must have private health insurance with full prescription coverage with no annual maximum and no pre-existing condition clause. All medical services other than emergencies must be provided in Michigan. The requirements are:

- 1) *You Must Be HIV + as Verified by a Physician or Nurse Practitioner.*
- 2) *Must Be A Michigan Resident.*

QUALIFICATIONS FOR THE IAP-PLUS PROGRAM(Continued)

- 3) *Gross Monthly Income Must Be Less Than or Equal To 450% of FPL. Proof of Your Income Is Required.*
- 4) *You Must Not Be Eligible For Any Employer Sponsored Health Insurance, other than Your Current Policy. Your policy must include full prescription coverage with no annual maximum*
- 5) *You Must Not Be Eligible For Full Medicaid Insurance.*

All Recipients Approved For The IAP-Plus Program Will Be Required to Submit Updated Income and Insurance Information Every (6) Months or As Soon As a Change Occurs. Any change in Insurance Status must be Reported Immediately.

APPLICATION PROCEDURE

Fill out the attached pages 3, 4, 5 and 6 of the application and return them in the mail. Page 5 must be completed by your physician or nurse practitioner.

Your application must include copies of the following:

1. **A Copy of Your Driver's License, or Government issued Photo ID with your Signature.**
2. **Income Verification**, See employment & income verification sources on page 3. If zero income, complete the Support Letter page 7.
3. **Medical Insurance Continuation Forms, or Premium Statements, or Bills.**

Application Must Be Completed in Blue Ink to verify Authenticity.

Faxed and Copied Applications Are Not Accepted. Mail the Original Completed Signed Application Form To:

MI DEPARTMENT OF HUMAN SERVICES
INSURANCE ASSISTANCE PROGRAM
3038 W. GRAND BLVD., STE. 4-550
DETROIT, MI 48202-6038

If You Have Any Questions, Please Call (313) 456-1677, (313) 456-3882 or 1-877-342-2437

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Be sure to answer all questions. Failure to fully complete this application will result in a delay.

APPLICATION MUST BE COMPLETED IN BLUE INK TO VERIFY AUTHENTICITY.

For Office Use Only

1. Your Full Name (Last, First, Middle)		2. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
3. Address (Number and Street)		4. City	5. State 6. Zip Code
7. Telephone Number ()		8. County	9. Social Security Number
10. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Partnered		11. Date of Birth	
12. RACE/ETHNICITY: <input type="checkbox"/> African American <input type="checkbox"/> Arab American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Chaldean <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other (Please Specify)			
13. Family Size (self, spouse, and/or dependents living with you)			

EMPLOYMENT AND INCOME INFORMATION (Provide Copies of Pay Stubs for current job - most recent full month)

1. Are You Currently Employed or Self Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No, If No, when was last date worked?			
2. Name of Employer		3. No. of Hrs. Worked Weekly	4. Gross Monthly Income
5. Are you eligible for COBRA Health Insurance Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Do you work at a new job that offers health insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If You Answered Yes to #6 Be Sure And Answer #7 Below			
7. When do you become eligible for health insurance benefits in your new job?			

OTHER INCOME [You must provide verification (proof) of income for the most recent full month.]

8. Do You Receive The Following? (Check All That Apply):	Gross Monthly Amount
<input type="checkbox"/> Social Security Benefits (SSI), (SSDI) or Proof of Application	
<input type="checkbox"/> Veterans Benefits	
<input type="checkbox"/> Unemployment Compensation Check stubs or Proof of Application	
<input type="checkbox"/> Private Long Term/Short Term Disability	
<input type="checkbox"/> Child Support	
<input type="checkbox"/> Spouse's Income.....	
<input type="checkbox"/> Other Income (Such as rental income, odd jobs, etc.)	

INSURANCE INFORMATION

1. What is the name of your health insurance company?	2. Who is your COBRA Administrator?	Telephone Number ()
3. Who is your benefits contact person?		Telephone Number ()

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ASSET INFORMATION

APPLICATION MUST BE COMPLETED IN BLUE INK TO VERIFY AUTHENTICITY.

ANSWER YES OR NO TO ALL ITEMS. IF YES, LIST CURRENT AMOUNT (INCLUDING THOSE HELD JOINTLY)

	CURRENT BALANCE
1. Checking/Draft Accounts..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Money Market..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Savings/Share Accts. <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Certificates of Deposits (CDs)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Patient Trust Fund..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Cash on Hand or in Safe Deposit..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Real Estate (Not Including Your Home)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Mortgage, Land Contracts etc. Paid to You..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Savings Bonds, Stocks or Mutual Funds..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. IRA, KEOGH, 401K Deferred Compensation..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Trust Funds..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Other Cash Assets (List)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

**I Certify, Under Penalty of Perjury, That All The Information That I Have Provided In This Form Is True.
Must Have Witness Signature or Application will be Returned.**

Print Applicant Name:	Print Witness Name:
Applicant Signature: Date	Witness Signature: Date
<p><small>This form is issued under authority of 45 CFR 206.10(a)(1)(ii); 42 CFR 435.907; 7 CFR 273.2(d); and Sections 24, 25 and 59 of Act 280 of the Public Acts of 1939, as amended. You must complete this form if you want the agency to consider your application for insurance assistance.</small></p>	<p><small>Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</small></p>

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TO BE COMPLETED BY A PHYSICIAN ONLY

APPLICATION MUST BE COMPLETED IN BLUE INK TO VERIFY AUTHENTICITY.

1. Patient Name	2. Social Security Number - -
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3. Method of Payment for Medical Services

Private Health Insurance
 Medicaid
 Medicare
 Other (Please Explain) _____

4. Length of time patient has been under your care?

Years _____ Months _____

5. Has this person tested positive for HIV?

Yes No

6. It is my judgment this patient is currently too sick to continue working in his/her current job.

Yes No

7. It is my judgment that because of a continuing disability, there is a substantial likelihood that within the next three months this patient will be too sick to work in his/her current job.

Yes No

Remarks:

Must be signed by D.O.; M.D.; or Nurse Practitioner

8. Print Physician's Name	9. Telephone Number ()	10. License Number (Required) - - - -	
11. Address	12. City	13. State	14. Zip Code
15. Physician's Signature			Date

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AGREEMENT AND AUTHORIZATION FOR EXCHANGE OF INFORMATION

THIS AGREEMENT MUST BE COMPLETED IN BLUE INK TO VERIFY AUTHENTICITY.

I certify, under penalty of perjury, that all information I have provided is true. I understand that giving false information will disqualify me from the IAP or IAP-Plus program and that I may be required to repay funds (or) be prosecuted criminally.

I agree that if I become eligible for employer-sponsored health insurance, other than my current COBRA insurance (if applicable), I will notify the IAP program immediately. I understand that all medical services are to be provided in Michigan, unless there is an emergency.

I authorize the Michigan Department of Human Services (MDHS) and the Michigan Department of Community Health (MDCH) to receive and disclose medical, financial, employment, and health insurance information from my medical staff, case management agency, Cobra administrator, employer and health insurance provider. This information is for the purpose of determining my initial and ongoing eligibility for the IAP and IAP-Plus programs and for the purpose of managing payments for my health insurance. This information may include obtaining records related to HIV, HIV evaluation and treatment (MCL 33.5131). Specific contacts/representatives are listed below.

I authorize MDCH, my insurance carrier, and MDHS IAP and IAP-Plus to release information that pertains to any cost studies conducted by MDCH, MDHS, or a selected contractor to determine IAP and IAP-Plus cost effectiveness. The purpose of those studies is to improve the efficiency and quality of services provided.

My failure to sign this authorization will severely impact the assistance MDHS and/or MDCH will be able to provide me.

This authorization will remain in effect until: 1) The need for the information no longer exists; 2) I withdraw the authorization in writing to the IAP or IAP-Plus. The information disclosed by MDHS and/or MDCH's use of this authorization may be subject to re-disclosure by the recipient, and such re-disclosure would not be protected by the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA).

Purpose of Release is for: Demographic Information, Eligibility Requirements and Coordination of Services My Case Manager Is:	Agency
Purpose of Release is for: Completion of Medical Release and Demographic Information My Physician or Nurse Practitioner Is:	My Health Insurance Co. Is:
Purpose of Release is for: Active Insurance Coverage, Premium Rates, Billing and Payment Issues, and Demographic Information My Employer's Benefits Person/Human Resource Person is:	My Benefits Person's Phone No. ()
Purpose of Release is for: Active Insurance Coverage, Premium Rates, Billing and Payment Issues, and Demographic Information My COBRA Administrator is: (Where premiums are mailed)	
Print Applicant/Parent or Guardian Name	Signature of Applicant/Parent or Guardian
Date	

Please mail originally completed pages 3, 4, 5 and 6 of the application to the address listed below. Photo copies and faxed copies will not be accepted. (Be sure you include copies of pay stubs or other income proof, a copy of your driver's license, and a copy of your insurance papers.)

**MI Department of Human Services
 Insurance Assistance Program
 3038 W. Grand Blvd. Ste. 4-550
 Detroit, MI 48202-6038
 Telephone: (313) 456-1677, (313) 456-3882 or 1-877-342-2437**

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability Accountability Act (HIPAA).

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**INSURANCE ASSISTANCE PROGRAM (IAP) OR
INSURANCE ASSISTANCE PROGRAM PLUS (IAP-PLUS)**

Support Verification Form

ONLY COMPLETE THIS FORM IF YOU HAVE NO INCOME.

I, _____, am providing support for
_____ on a **monthly basis** in the following manner:

Answer yes or no to all items. If yes, list amount.

	<u>Yes</u>	<u>No</u>
1. Rent/Room & Board/Shelter	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
2. Food	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
3. Bill(s) Paid for client	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
4. Cash Given to client	<input type="checkbox"/> \$ _____	<input type="checkbox"/>

Signature of Person Providing Support Date

Print Name of Person Providing Support _____

Address _____

Phone # _____