INSURANCE ASSISTANCE PROGRAM (IAP)

Michigan Department of Health and Human Services

Dear Applicant:

Thank you for your interest in the Insurance Assistance Program (IAP). This program was developed to assist individuals to maintain and continue their health insurance benefits while facing financial difficulty due to their specific illness. The IAP program pays health insurance premiums for eligible individuals.

QUALIFICATIONS FOR THE IAP PROGRAM

All medical services other than emergencies must be provided in Michigan. The requirements are:

1. You must be HIV+ and must be currently be too ill to work in your current job, or there is a substantial likelihood you will be too ill to work within the next 3 months, as verified by a physician or nurse practitioner.

2. You must be a Michigan resident.

3. Your gross monthly income must be less than or equal to 200% of the Federal Poverty Level (FPL). **Proof of your income is required.**

4. You must not have more than $10,000 in total cash/liquid assets. **Proof of assets is required.**

5. You must not be eligible for any employer sponsored health insurance, other than your current policy.

6. You may be eligible for Medicaid.

7. You must **complete, sign and date** the DHS-1661 application.

All recipients approved for the IAP program will be required to submit updated income, asset, and insurance information annually or sooner if a change occurs.

APPLICATION PROCEDURE

Applicants must complete the attached pages of the DHS-1661 application and return them via fax or mail. The Medical Certification page must be completed by your physician or nurse practitioner.

Your application must include copies of the following:

1. Your Michigan driver's license or government issued photo ID with your signature.

2. Income verification, see employment & income verification sources on the application. If you do not have any income the Support Verification Form page must be completed.

3. Premium statements/bills.

4. Verification of assets.

5. Confirmation of application to Medigap Subsidy at http://www.michiganmedigapsubsidy.com.

Applications should be **mailed** to the address below or **faxed** to **517-335-7723**.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
INSURANCE ASSISTANCE PROGRAM
109 W. MICHIGAN AVENUE, 9th FLOOR
LANSING, MI 48913

If you have any questions, please call 877-342-2437.

INSURANCE ASSISTANCE PROGRAM (IAP) APPLICATION

Michigan Department of Health and Human Services

Failure to fully complete this application will result in a delay of eligibility determination or application denial.

1. Your Full Name (Last, First, Middle)		2. Email Address	
3. Address (Number and Street)	4. City	5. State	6. Zip Code
7. County	8. Telephone Number (Home) – –	9. Telephone Number (Cell) – –	
10. Gender ☐ Male ☐ Female ☐ Male to Female ☐ Female to Male		11. Date of Birth	12. Social Security Number
13. Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Partnered		14. Family Size (self, spouse, and/or dependents living with you)	
15. Preferred Name (if applicable)			

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

1. Are You Currently Employed or Self Employed? ☐ Yes ☐ No If no, when was last date worked?		
2. Name of Employer	3. No. Hrs. Worked Weekly	4. Gross Monthly Income
5. Are you eligible for COBRA Health Insurance Benefits? ☐ Yes ☐ No		
If You Answered Yes to #6 Be Sure and Answer #7 Below		
6. Do you work at a new job that offers health insurance benefits? ☐ Yes ☐ No		
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		Gross Monthly Amount
☐ Social Security Benefits		☐ Veterans Benefits	
☐ Child Support		☐ Long Term/Short Term Disability	
☐ Spouse's Income		☐ Retirement Benefits	
☐ Unemployment or Worker's Compensation		☐ Other Income (Such as rental income, odd jobs, etc.)	

INSURANCE INFORMATION (Check off your coverage type)

☐ Medigap/Medicare Supplement ☐ MED-D

ASSET INFORMATION

Check all that apply and list current amount (including those held jointly). Provide proof.	
	Current Balance
☐ Checking/Draft Accounts	
☐ Money Market	
☐ Savings/Share Accts.	

	Current Balance
☐ Certificates of Deposits (CDs)	
☐ Cash on Hand or in Safe Deposit	
☐ Savings Bonds, Stocks or Mutual Funds	
☐ IRA, KEOGH, 401K Deferred Compensation	
☐ Trust Funds, Land Contracts, Real Estate (Not including your home)	
☐ Other Cash Assets (List)	
☐ None	

AGREEMENT AND AUTHORIZATION FOR EXCHANGE OF INFORMATION

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 program and that I may be required to repay funds (or) be prosecuted criminally.

I agree to report all changes within ten business days if my situation changes.

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 agree to return to the State of Michigan any refunds I receive form my insurance carrier that are a result of IAP payments.

I authorize the Michigan Department of Health and Human Services (MDHHS) 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 program 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 MDHHS, my insurance carrier, and IAP to release information that pertains to any cost studies conducted by MDHHS, or a selected contractor to determine IAP 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 MDHHS 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. The information disclosed by MDHHS 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 Name Telephone Number – –
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:	Agency Name Telephone Number – –

Please mail originally completed pages of the application to the address listed below. Photo copies and faxed copies will 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.)

Michigan Department of Health and Human Services
Insurance Assistance Program
109 W. Michigan Avenue, 9th Floor
Lansing, MI 48913
Telephone: 877-342-2437 Fax: 517-335-7723

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

I certify, under penalty of perjury, that all the information that I have provided in this form is true.

Print Applicant Name	Applicant Signature	Date

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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MEDICAL CERTIFICATION

Michigan Department of Health and Human Services

TO BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER ONLY

1. Patient Name	2. Social Security Number
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 – required	

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

SUPPORT VERIFICATION REQUEST

THIS FORM SHOULD BE COMPLETED IF YOU HAVE NO INCOME.

IT SHOULD BE COMPLETED BY THE INDIVIDUAL PROVIDING SUPPORT (NOT THE APPLICANT).

I, _____, am providing support for

_____ on a **monthly basis** in the following manner:

Answer yes or no to all items.			**If yes, list amount.**
1. Rent/Room and Board/Shelter	☐ Yes	☐ No	$ _____
2. Food	☐ Yes	☐ No	$ _____
3. Bill(s) paid for client	☐ Yes	☐ No	$ _____
4. Cash given to client	☐ Yes	☐ No	$ _____

Signature of Person Providing Support		Date	
Print Name of Person Providing Support		Phone Number	
Address	City	State	Zip Code