Form G - Ryan White Part B Program Application Instructions

The Ryan White Part B Program gives help to low income people living with HIV/AIDS in Maine.

Use this application to apply for help paying for health insurance.	Help with health insurance is available for people with HIV/AIDS who: • live in Maine; • make less than 500% of the federal poverty level (https://aspe.hhs.gov/poverty-guidelines); AND • can't get help anywhere else.
What you need to apply:	• Complete and sign the 1-page application. • Send us a bill for your health insurance and the DHHS release form so we can talk to your insurance company if we have questions about the payment. • Payment must be made to the insurance company or employer directly. ADAP **cannot** reimburse clients for premiums deducted from paychecks.
How you apply:	• Send your completed application and attachments to: **Maine Ryan White Program** **40 State House Station** **Augusta, ME 04330** **Fax: (207) 287-3498**
What happens next?	• Fill out the application completely and clearly. We can't process applications with missing information. (Your Ryan White ID is the same DHS number you use for ADAP.) • Once we receive your complete application, you will get a letter to let you know if payment has been approved or denied. • Please allow up to ten business days for your application to be processed. If you do not hear from us in ten business days, please call us.
Get help with this application	• Phone: (207) 287-3747. TTY users call Maine Relay 711 • Fax: (207) 287-3498 • Email: RyanWhitePartB@maine.gov

In accordance with 22 MRS §15, any person who knowingly makes any false written statements or knowingly submits any false documents to receive benefits provided by the Department may face civil penalties by the State of Maine in the Superior Court, which may include, but is not limited to, recovery of those funds disbursed.

Maine Department of Health and Human Services
NONDISCRIMINATION NOTICE

The Department of Health and Human Services ("DHHS") does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices. This notice is provided as required by and in accordance with Title II of the Americans with Disabilities Act of 1990 ("ADA"); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972; Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination. Questions, concerns, complaints or requests for additional information regarding the ADA and *hiring or employment practices* may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-4289 (V); 207-287-1871(V); or Maine Relay 711 (TTY). Questions, concerns, complaints or requests for additional information regarding the ADA and *programs, services, or activities* may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-3707 (V); Maine Relay 711 (TTY); or ADA-CivilRights.DHHS@maine.gov. Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator. This notice is available in alternate formats, upon request.

Form G - Ryan White Part B Program
Application for Assistance with
Private Individual Insurance Premiums

1. Client Information

Name: _____ Ryan White ID: DHS_____

2. Insurance Information

Health insurance company: _____

Monthly premium amount: $_____

Account/policy number: _____

Policy start date: _____/_____/_____

3. Attachments

This application will not be considered complete without required attachments.

Please attach:

- A current bill for your health insurance
- Release forms to talk to your health insurance company
  - **Community Health Options:** Authorization for Disclosure of Protected Health Information
  - **Harvard Pilgrim:** (1) Member Authorization to Release Information and (2) Designated Representative
  - **Any other insurance:** the insurance company's release of information form

4. Client Agreement

Initial all areas below in order to receive insurance assistance:

_____ I understand that I have to contact ADAP within 10 days if my address, phone number, or income changes.

_____ I understand that I have to recertify with ADAP every year or I could lose assistance with my insurance.

_____ I understand ADAP has to pay the insurance company.

_____ I understand I have to give ADAP a premium bill at the start of every year **and** if my premium changes.

_____ I understand that if I receive any tax credits or subsidy, I must complete my federal taxes and contact CoverME.gov when my income changes. If I receive a refund for overpayment of premiums, I must pay the refund back to ADAP. If I owe taxes for underpayment of premiums, I will contact ADAP to pay them.

_____ I understand that if I receive checks from from my insurance for over payment of premiums and/or copays that the check has to be sent to ADAP, and I should sign the back "pay to Medical Care Development."

_____ I understand if I lose my insurance, I may not be able to get insurance until the next open enrollment period.

_____ All information I shared on this form is true.

Printed Name	Signature	Date
_____	_____	_____

Office use only:

Date Received: Date Complete: Date Entered:

End date: ☐ Approved. ☐ Not approved. Reason: Staff initials: