# 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:<br>• live in Maine;<br>• make less than 500% of the federal poverty level (https://aspe.hhs.gov/poverty-guidelines); AND<br>• can't get help anywhere else. |
| **What you need to apply:** | • Complete and sign the 1-page application<br>• Send us a bill for your health insurance and the CHO Authorization form so we can gwt your monthly bills and talk to your insurance company if there are questions about the payment |
| **How you apply:** | • Send your completed application and attachments to:<br>**Maine Ryan White Program**<br>**40 State House Station**<br>**Augusta, ME 04330**<br>**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.)<br>• Once we receive your complete application, you will get a letter to let you know if payment has been approved or denied.<br>• 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<br>• Fax: (207) 287-3498<br>• Email: RyanWhitePartB.DHHS@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.

# Ryan White Part B Program
# Application for Assistance with
# Community Health Options Premiums

## 1. Client Information

Name: _____ Ryan White ID: DHS_____

## 2. Insurance Information

Health insurance carrier: Community Health Options

Monthly premium amount: $_____ Policy ID: _____

## 3. Attachments

**This application will not be considered complete without required attachments.**

Please attach:

- A bill for your health insurance
- Community Health Options Authorization for Disclosure of Protected Health Information

## 4. Client Agreement

***Initial all areas below in order to receive insurance assistance:***

_____ I understand that I have to contact ADAP within 10 days of any change to my address, phone number, or income. If I do not notify ADAP of these changes, I could lose my insurance.

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

_____ I understand that I have to give ADAP a bill for my insurance at the beginning of every year **and** any time my premium changes.

_____ I understand that if I receive any tax credits or subsidy, I must complete my federal taxes and contact HealthCare.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 any checks from Community Health Options for over payment of premiums and/or copays that the check has to be sent to ADAP.

_____ I understand that if I I lose my insurance, I might not be able to get insurance until the next open enrollment period and may have to pay a tax penalty.

_____ All information I shared on this form is true.

| Printed Name | Signature | Date |
|---|---|---|
| | | |

**Office use only:**

☐ Approved. ☐ Not approved. Reason:

End date: Staff initials:

COMMUNITY Health Options™

# Authorization for Disclosure of Protected Health Information (PHI)

**Instructions: This form is to be completed by a current or former Member to authorize Health Options and its employees to release PHI to a designated person. Section I must be completed to be valid and Section II is optional. Please print clearly.**

- You may only specify one person to whom the information may be disclosed per form.
- In Section I you can choose to release all information or just a limited amount. If you choose the limited option, be sure to check the specific information you want disclosed.
- Section II applies to sensitive information. You can leave it blank, release all, or choose specific topics. If you choose specific topics, make sure to check them off on the form.
- Sign and date the form as instructed at the bottom of the form. If you have questions about how to fill out this form, call Member Services at (855) 624-6463.

**Section I**

_____

Current/Former Member's Full Name

_____ _____

Current/Former Member Date of Birth | Current/Former Member ID#

This will authorize Community Health Options (Health Options) and its employees to disclose my Protected Health Information (PHI) to: (name only one person per form)

Maine ADAP

_____

Name of Authorized Representative

286 Water St, 6th floor, Augusta, ME 04330

_____

Address/City/State/ZIP

207-287-7028 _____ 207-287-3498 _____

Phone# | Fax#

**I authorize the disclosure of the following types of information by Health Options: (Required, check one box below)**

☑ All my information. This can include health, diagnosis (name of illness or condition), claim, doctor, and other healthcare providers and financial information (like billing and banking). This does not include sensitive information unless it is approved in Section II below.

**OR**

☐ Only limited information may be released (check all circles below that apply to you).

Authorization for Disclosure of Protected Health Information

- o Appeals
- o Benefits and coverage
- o Claims and payment
- o Diagnoses (name of illnesses or conditions) and procedures (treatment)
- o Eligibility and enrollment
- o Financial information
- o Invoicing
- o Medical records
- o Doctors and hospitals
- o Pre-certification and preauthorization (for treatment approvals)
- o Referrals
- o Treatments
- o Dental
- o Vision
- o Pharmacy
- o Other: _____

CONFIDENTIALITY NOTICE: This communication was reviewed for compliance with applicable privacy standards prior to distribution. All parties sending, handling or storing protected health information are obliged to meet relevant HIPAA standards. This communication is intended only for the use of the individual to which it is addressed. If you have received this communication in error, please notify Community Health Options immediately at (855) 624-6463. This communication and its information may be protected by federal and/or state privacy and confidentiality rules. You are hereby notified that any disclosure, dissemination, or copying of this communication or its information is prohibited unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

**Section II (Optional)**

**I authorize the disclosure of the following types of sensitive information by Health Options: (check one box below only if it is applicable)**

☑ All Sensitive Information

**OR**

☐ Specific information about topics (check all circles below that apply to you).

- o Abortion
- o Abuse (sexual/ physical/mental)
- o Alcohol/substance use disorder*
- o Genetic testing
- o HIV or AIDS
- o Maternity
- o Sexually transmitted illness
- o Mental Health (ex. psychotherapy notes)
- o Other: _____

*I understand that my alcohol/substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand that I cannot cancel this approval when this form has already been used to disclose information.

**By signing below:**

I intend this authorization to apply to disclosures of PHI that Health Options has received from other persons or entities. I authorize that subsequent disclosures of PHI within the scope of this authorization may be made pursuant to this same authorization.

I understand that:

- I am entitled to a copy of this authorization.
- I may revoke this authorization in writing delivered to Health Options' Privacy Officer at any time, although revocation will not be effective to the extent anyone has already relied on the authorization.
- PHI used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- Health Options shall not condition treatment, payment or enrollment in a health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

Current Members: This authorization will expire two (2) years from the date of the signature or when the policy is no longer active – whichever comes first. If you prefer a shorter time in which this authorization is valid, please indicate the date it would expire: _____

Former Members: This authorization will expire after one (1) year from the date of the signature. If you prefer a shorter time in which this authorization is valid, please indicate the date it would expire: _____

_____

Signature of current/former Member (or their Legally Authorized Representative)** Date

_____

**Authority or relationship of authorized representative

**Send us the completed form via email (preferred), postal mail or fax.**

- Email to: Enrollment@HealthOptions.org
- Mail to: Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243
- Fax to: Community Health Options, 207-402-3745, Attn: Privacy Officer