

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.

<p>Use this application to apply for help paying for Medicare Part D premiums.</p>	<p>Help with health insurance is available for people with HIV/AIDS who:</p> <ul style="list-style-type: none"> • 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.
<p>What you need to apply:</p>	<ul style="list-style-type: none"> • 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 • ADAP can only pay Part D premiums if you do not have MaineCare. • Payment must be made to the insurance company directly. ADAP cannot reimburse clients for premiums deducted from paychecks.
<p>How you apply:</p>	<ul style="list-style-type: none"> • Send your completed application and attachments to: Maine Ryan White Program 40 State House Station Augusta, ME 04330 Fax: (207) 287-3498
<p>What happens next?</p>	<ul style="list-style-type: none"> • 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.
<p>Get help with this application</p>	<ul style="list-style-type: none"> • Phone: (207) 287-3747. TTY users call Maine Relay 711 • Fax: (207) 287-3498 • 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 Medicare Part D Premiums



1. Client Information

Name: _____ Ryan White ID: DHS _____

2. Insurance Information

Health insurance company: _____ *

Address for payment:

Monthly premium amount: \$ _____ Account/policy number: _____

* Payment must be made to the insurance company directly. ADAP **cannot** reimburse clients for premiums deducted from paychecks.

3. Attachments

This application will not be considered complete without required attachments.

Please attach:

- A bill for your Medicare Part D premiums
- The Maine Department of Health and Human Services Authorization to Release Information form filled out with your health insurance company's 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 contact information (address or phone number) or risk losing my insurance. If 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.

_____ I understand that I have to recertify with ADAP every six months or risk losing my insurance. If 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.

_____ I understand that I have to give ADAP a bill for my insurance every year to be sure the right amount is getting paid **or** anytime my premium changes.

_____ I understand that if I receive any checks from my insurer for over payment of premiums and/or copays that the check has to be sent to ADAP.

_____ All information I shared on this form is true.

_____ Printed Name

_____ Signature

_____ Date

Office use only:

Approved. Not approved. Reason:

End date:

Staff initials: