

HEALTH INSURANCE PREMIUM PAYMENT, HIPP, APPLICATION

WHO IN YOUR HOUSE IS CURRENTLY WORKING? (NAME) _____ (SSN) _____ (DATE OF BIRTH) ____/____/____	WHO IN YOUR HOUSE IS CURRENTLY WORKING? (NAME) _____ (SSN) _____ (DATE OF BIRTH) ____/____/____	
WHO IN YOUR HOUSE LOST A JOB IN THE LAST 30 DAYS OR MAY BE ELIGIBLE FOR COBRA? (NAME) _____ (SSN) _____	WHO IN YOUR HOUSE LOST A JOB IN THE LAST 30 DAYS OR MAY BE ELIGIBLE FOR COBRA? (NAME) _____ (SSN) _____	
EMPLOYER/COMPANY _____ EMPLOYER PHONE # _____ () - _____	EMPLOYER/COMPANY _____ EMPLOYER PHONE # _____ () - _____	
EMPLOYER/COMPANY ADDRESS _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE) _____	EMPLOYER/COMPANY ADDRESS _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE) _____	
DOES YOUR EMPLOYER OFFER HEALTH INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/>	DOES YOUR EMPLOYER OFFER HEALTH INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF YES: When are you eligible? <input type="checkbox"/> ANYTIME <input type="checkbox"/> DATE: ____/____/____	IF YES: When are you eligible? <input type="checkbox"/> ANYTIME <input type="checkbox"/> DATE: ____/____/____	
IF YES: Who is covered?	IF YES: Who is covered?	
WHO CAN BE ADDED:	WHO CAN BE ADDED:	
IS ANYONE IN THE HOUSEHOLD PREGNANT? YES <input type="checkbox"/> NO <input type="checkbox"/> NAME: _____ DUE DATE: ____/____/____		
IS ANYONE IN THE HOUSEHOLD RECEIVING TREATMENT FOR A SERIOUS ILLNESS?		
NAME	ILLNESS	NAME AND PHONE NUMBER OF DOCTOR
		() - _____
		() - _____
		() - _____
I hereby authorize and request the disclosure to the PA Dept. of Public Welfare any information that would be needed to determine eligibility for the Health Insurance Premium Payment, HIPP, Program, and appoint the department my limited attorney-in-fact with the power to elect group health benefit coverage on my behalf, to enroll me in such coverage and to pay premiums or contributions on my behalf. This power of attorney shall remain in effect until revoked in writing by me. I understand this information will be kept confidential and will be used only for the purpose of determining eligibility for the HIPP Program. In compliance with Federal HIPAA privacy regulations, I understand and agree that the HIPP Program may use and disclose protected health information (including but not limited to name, address, diagnosis and treatment) for treatment, payment or health care operations. I understand that I must consent to this use and disclosure in order to enroll in or receive services through the HIPP Program.		
Employee Signature(s): _____		DATE: ____/____/____
Phone Number(s): Home: () - _____ Cell: () - _____ Work: () - _____		