Iowa Department of Human Services

AIDS/HIV HEALTH INSURANCE PREMIUM PAYMENT QUARTERLY REVIEW

Name	Date
Address	Worker name
	Telephone 1-888-346-9562

General Directions:

The information submitted on this form will be used to establish your continued eligibility for the AIDS/HIV Health Insurance Premium Payment (HIPP) Program. Please answer each question below for each of the three months listed. Those questions marked with a star (*) require that verification be returned with the form. Return the completed form and the required verifications no later than . **Failure to return this information by the deadline may result in the cancellation of your AIDS/HIV HIPP Program.**

	Month 1	**Month 2**	**Month 3**
1. List everyone living with you each month.	Living with you in this month? (Check One)	Living with you in this month? (Check One)	Living with you in this month? (Check One)
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*2. Resources. Please provide **current** proof of all resources.

	Applicant	**Spouse**	**Children**
A. Cash on hand			
B. Checking accounts			
C. Savings accounts			
D. Stocks or bonds			
E. Trust fund			
F. Cash value of life insurance/annuities			
G. Certificates of deposit/mutual funds			
H. Other (identify)			

*3. Earned income. Send in **all** paystubs from earnings or other proof of income such as tip records from related household members. If you are self-employed, send in a copy of your business records for each month.

Month		Month		Month	
Name		Name		Name	
Employer		Employer		Employer	
Date Received	**Amount**	**Date Received**	**Amount**	**Date Received**	**Amount**

*4. Unearned income. List all gross, unearned income received and the name of the person who received it for each month indicated. Send proof when this income begins, changes or ends.

	Month	Month	Month
	Name	Name	Name
	Amounts Below	**Amounts Below**	**Amounts Below**
Social Security disability			
Other disability income			
Unemployment income			
Child support/alimony			
Retirement income			
Other unearned income			

*5. Insurance benefits.	Check One	If yes, date of change.
Did your insurance premium change?	☐ Yes ☐ No	
Did the benefits covered under your policy change?	☐ Yes ☐ No	
Did your insurance coverage stop?	☐ Yes ☐ No	
Has your insurance plan changed to COBRA?	☐ Yes ☐ No	
If you answered "Yes" to any of the above questions, explain and send proof of any changes.		

6. Explanation of your answers. (Attach additional pages, if necessary.)
If anyone has moved in or out of your home, explain:
Other:

7. Signature and date. **Read these statements carefully before you sign.**

- ☐ I certify that these statements are correct to the best of my knowledge and belief.
- ☐ I know that the facts that I have given on this report may cause my assistance to be reduced or terminated.
- ☐ I understand that I may have to repay the Department of Human Services for any money that is received by me or paid to a vendor on my behalf to which I was not entitled.
- ☐ I understand that as a condition of eligibility for this program, I may be required to apply for and accept Medicaid (Title 19).
- ☐ I understand that my eligibility for this program will cease if funding is exhausted.
- ☐ I understand that I am required to report changes in my circumstances to the AIDS/HIV Health Insurance Premium Payment Program staff within ten days of the change. Changes to be reported include (but are not limited to): income changes, resources, employment status, health insurance coverage, health insurance premium, and address.
- ☐ I am aware that Iowa laws provide that anyone who obtains or tries to obtain or helps any person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the State of Iowa, including Iowa Code Chapters 239, 249, and 249A.

Signature or mark of the recipient	Date
Signature of person, if any, who helped complete form	Date

Witness to mark of recipient, if recipient is unable to sign	Date