

Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program

KI  **HIPP**

Kentucky Integrated Health Insurance Premium Payment Program

Notice Guide

Last Update: August 2021

TEAM 
KENTUCKY

What is KI-HIPP?

The **Kentucky Integrated Health Insurance Premium Payment (KI-HIPP)** program is a voluntary Medicaid program offered to Medicaid members to help pay for the cost of an Employer-Sponsored Insurance (ESI) plan, which is usually offered through current or past employment (COBRA, United Mine Workers, or Retiree Health Plan). In addition, enrolled members may also include Non-Medicaid policy holders with at least one Medicaid member on the plan.

KI-HIPP aims to help families with at least one person enrolled in Medicaid pay for the cost of health insurance premiums, which is the amount paid to a health insurance company for coverage. Once enrolled in KI-HIPP, the policy holder will receive ongoing payments to help cover the cost of health insurance premiums.

This **Notice Guide** is designed to help you understand what each notice means for you and to answer questions you may have.



For any questions about the KI-HIPP program,
please call **855-459-6328**.

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Before we get started...

It's important to note that there are several notices that individuals may receive from the KI-HIPP program. This **Notice Guide** groups the notices into sections to help make it easier to find the notice you are looking for!

The table below describes the general purpose of the sections and lists the corresponding notices in each section.

Section Description	Notices
<p><u>KI-HIPP Eligibility</u></p> <p>Notices that notify you that you may be eligible for KI-HIPP. These notices may also tell you how to begin enrollment.</p>	<ul style="list-style-type: none"> • Access Program Notice • Enrollment Program Notice • Enrollment Program Notice Insert • KI-HIPP Potential Eligibility Notice
<p><u>Enrolling in KI-HIPP</u></p> <p>Notices that you may receive during and after the enrollment process for KI-HIPP.</p>	<ul style="list-style-type: none"> • Notice of Invalid/Incomplete Document • Notice of Health Insurance Plan Review • MCO Disenrollment Letter • KI-HIPP Notice of Eligibility • KI-HIPP Notice of Eligibility Insert • KI-HIPP Application Summary • Did You Know Notice • Notice of Privacy Rights
<p><u>Reminders for Enrolled Members</u></p> <p>Notices that remind enrolled KI-HIPP members to provide certain documents or information in order to continue receiving KI-HIPP payments.</p>	<ul style="list-style-type: none"> • Notice of Health Insurance Plan Review • Notice of Action: Submit Premium Payment Proof • Notice of Premium Change • Notice of Renewal • Renewal Reminder Notice
<p><u>Notices about KI-HIPP Payments/Claims</u></p> <p>Notices that notify enrolled KI-HIPP members if there is a change in their KI-HIPP payments or outstanding claims.</p>	<ul style="list-style-type: none"> • Direct Deposit Failure Notice • Benefits Reduction Notice • Claim Adjustment Notice • Claim Termination Notice • Notice of KI-HIPP Supplemental Payment
<p><u>Notices for Disenrolled Members</u></p> <p>Notices for members that have been disenrolled from KI-HIPP. These notices may request outstanding claims or notify the disenrolled member that their Good Cause request has been rejected.</p>	<ul style="list-style-type: none"> • Demand Notice • Payment Past Due Notice • Payment Receipt Notice • Claim Adjustment Notice • Good Cause Rejection Notice

KI-HIPP Eligibility


Description

Access Program Notice tells the individual that they may be eligible for KI-HIPP because they have access to a qualifying health insurance plan as a policy holder.

Why am I receiving this notice?

This notice explains that you may be **eligible** for KI-HIPP because:

- ✓ You and/or family member(s) on your case are **enrolled in Medicaid**
- ✓ You are **NOT** currently enrolled, but have **access** to one of the following types of coverages as a policy holder:
 - Employer-Sponsored Insurance (ESI)
 - Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - Retiree Health Plan
 - United Mine Workers
- ✓ You are **NOT** currently enrolled in KI-HIPP



Why I am receiving this notice?
You or someone in your household has reported access to health insurance through Employer. Based on this information, members covered under the health plan may be **eligible** for the Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) program.

What is KI-HIPP?
KI-HIPP is a program that lets Medicaid help you pay for the cost of private health insurance. You or someone in your household may be eligible for KI-HIPP if the plan is cost effective (affordable).

You will not lose Medicaid benefits by enrolling in KI-HIPP.

Where do I provide this information?

Upload the documents on kynect.ky.gov/benefits
Email the documents to KIHIPPPROGRAM@KY.GOV

Mail the documents to CHFS, KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort, KY 40621


After you have submitted the required documents, you do not need to do anything else. We will review your case and you will be notified if you are eligible for the KI-HIPP program. If you have questions, call us at 855-459-6328.

For additional information, please review the KI-HIPP Member handbook. The Member Handbook can be found at <https://chfs.ky.gov/agencies/dms/member/Documents/KIHIPPHandbook.pdf>.

How can KI-HIPP benefit me?

The KI-HIPP program provides many additional benefits like:

- Your family will have access to the doctors and benefits in Medicaid and your private insurance plan.
- You will receive a payment to help pay for your share of the health insurance premium.
- You will continue to have access to Medicaid benefits.




Sounds great! How do I get KI-HIPP?

To begin the process, ask your employer or insurance company for a copy of the:

- **Summary of Benefits and Coverage (SBC)** form; and
- **Premium Rate Sheet** for insurance plan.

Send these forms to Medicaid.



What are my next steps?

To check if you are eligible to enroll in KI-HIPP, send **both** of the following documents:

- ✓ **Summary of Benefits and Coverage (SBC)** showing the benefits covered by your ESI plan
- ✓ **Premium Rate Sheet** showing the charges and rates of your employer's health insurance plans

You can send these documents to the KI-HIPP Team in one of the following ways:

Upload:
kynect.ky.gov

Mail:
CHFS KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort, KY 40621

Email:
kihipp.program@ky.gov

Description

Enrollment Program Notice tells the individual that they may be eligible for KI-HIPP because they are enrolled in a qualifying health insurance plan as a policy holder.

Why am I receiving this notice?

This notice explains that you may be **eligible** for KI-HIPP because:

- ✓ You and/or family member(s) on your case are **enrolled in Medicaid**
- ✓ You are **enrolled** in one of the following types of coverage as a policy holder:
 - Employer-Sponsored Insurance (ESI)
 - Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - Retiree Health Plan
 - United Mine Workers
- ✓ You are **NOT** currently enrolled in KI-HIPP



You or someone in your household may be eligible!

Source of Coverage	Health Plan Name
Insurance through EMPLOYER	HEALTH PLAN

You or someone in your household has reported enrollment in the health plan listed below. Members covered under the health plan may be **eligible** for the Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) program!

What is KI-HIPP?
KI-HIPP is a program that helps families with a Medicaid member(s) pay for a **group health insurance plan**, which is usually offered through an employer.

Where do I send this?

Upload the documents on
kynect.ky.gov/benefits

Email the documents to
KIHIPP.PROGRAM@KY.GOV

Mail the documents to
CHFS, KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort KY, 40621

**** If you have questions, call us at 855-459-6328. ****

Medicaid members will NOT lose their Medicaid benefits by enrolling in the KI-HIPP program.

How can KI-HIPP benefit?

Enrolling in the KI-HIPP program could give you additional benefits such as:

- Access to a larger network of doctors and specialists from Medicaid **AND** your private insurance
- Payments (to the Primary Policy holder) to help pay for your share of the premium
- Continued access to Medicaid benefits (to Medicaid members ONLY)

Sounds great! How do I get KI-HIPP?

To begin the process, Primary Policy Holder will need to apply for KI-HIPP program by

1. Visiting kynect.ky.gov/benefits; or
2. Calling the 855-459-6328; or
3. Visiting in person to DCBS office. To find a DCBS office near you go to https://prdweb.chfs.ky.gov/Office_Phone/index.aspx.

You will need to give us a copy of each of these documents

1. **Summary of Benefits and Coverage (SBC)** form; **AND**
2. Your **insurance card** or a document showing proof of coverage; **AND**
3. **Premium Rate Sheet** for insurance plan; **AND**
4. **Proof of health insurance premium payment.**

What are my next steps?

To see if you are eligible to enroll in KI-HIPP, send in **all** of the following documents:

- ✓ **Summary of Benefits and Coverage (SBC)** showing the benefits covered by your ESI plan
- ✓ **Copy of your paystub** showing that the premium was taken out to pay for health insurance
- ✓ **Premium Rate Sheet** showing charges and rates of your health insurance plan
- ✓ **Copy of your insurance card** or a document from your health insurance company showing that you are enrolled in a health insurance plan

You can send these documents to the KI-HIPP Team in one of the following ways:

Upload:
kynect.ky.gov

Mail:
275 E. Main St., 6C-A
Frankfort, KY 40621

Email:
kihipp.program@ky.gov

* More information on KI-HIPP benefits can be found on page 54.

Description

Enrollment Program Notice Insert provides more information about KI-HIPP to potentially eligible policy holders with at least one Medicaid member on the plan.

Why am I receiving this notice?

This Enrollment Program Notice Insert is sent along with the Enrollment Program Notice to the policy holder when the following criteria are met:

1. Policy holder is enrolled in a qualifying health insurance plan **and**
2. At least one member on the policy is enrolled in Medicaid

This insert provides more information on the following topics:

- ✓ Benefits that you and/or your family may receive by enrolling in KI-HIPP
- ✓ How to enroll in the KI-HIPP program
- ✓ How to receive KI-HIPP payments that help pay for the cost of premiums
- ✓ How to set up direct deposit for receiving KI-HIPP payments

Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program Information	
What is the KI-HIPP Program?	KI-HIPP is a program that helps Medicaid members pay for the costs of premiums for a group health insurance plan, which is usually offered through an employer. For additional information please review the KI-HIPP Member handbook. The Member Handbook can be found at https://chfs.ky.gov/agencies/dms/member/Documents/KIHIPPHandbook.pdf
I already have Medicaid. Why should I sign up for KI-HIPP?	KI-HIPP provides: <ul style="list-style-type: none"> • Payment for the insurance premium • Access to the benefits and provider network of the group health plan • Access to Medicaid-covered services through Medicaid wrap-around benefits
How do I qualify for KI-HIPP?	To qualify for KI-HIPP, you or your dependent need to be enrolled in Medicaid first. Next, you must have access to a group health insurance plan. Group health insurance is usually offered through your employer. Other types of group health insurance plans include COBRA, Retiree Health Plan, or United Mine Worker Insurance.
What is the KI-HIPP process?	Follow the process below for KI-HIPP:

I was approved for KI-HIPP. When do I submit my next premium payment proof?	To receive your ongoing KI-HIPP premium payments, you need to submit proof of premium payment every time you receive a notice to do so. You will get a reminder notice to submit the payment verification proof during your health plan coverage renewal period. For example, if your plan coverage period ends in December 2020, you will need to submit a paystub in the month of November 2020 or December 2020. If your household's circumstances have changed or there has been a change in your policy, you need to submit proof of the change to the KI-HIPP team as early as possible to re-evaluate your KI-HIPP benefits. The KI-HIPP Program performs random audits. If you do not provide the requested information by the due date, you may lose your KI-HIPP benefits. You may receive a notice to provide additional proof of premium payment if you are picked during an audit. You may receive additional correspondence from the KI-HIPP Program, please ensure that you are checking your mail or email regularly. You can send a paystub that shows the premium payment was taken out of your paycheck or proof of payment from your insurance company through: <ul style="list-style-type: none"> • Self-service portal (kyconnect.ky.gov/benefits) • Email: KIHIPPPROGRAM@KY.GOV • Mail: CHFS, KI-HIPP Unit 275 E. Main St., 6C-A Frankfort, KY 40621
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Step 1	Step 2	Step 3	Step 4
<p>Complete Application</p> <p>Primary Policy Holder will complete the application via:</p> <ol style="list-style-type: none"> 1. Self-Service Portal (kyconnect.ky.gov/benefits) 2. In-person to DCBS Office 3. Over the phone calling 855-459-6328 	<p>Submit Documentation</p> <p>Submit required documents via:</p> <p>kyconnect.ky.gov/benefits</p> <ol style="list-style-type: none"> 1. Email: KIHIPPPROGRAM@KY.GOV 2. Mail: CHFS, KI-HIPP Unit 275 E. Main St., 6C-A Frankfort, KY 40621 	<p>Eligibility Determination</p> <p>After you send the required documents, the KI-HIPP team will review your case and let you know if you are eligible</p>	<p>Receive Payment</p> <p>Once you are enrolled in KI-HIPP, you must do the following to get the payment:</p> <ol style="list-style-type: none"> 1. Pay your health insurance premium 2. Send proof of premium payment every time you receive a notice to do so. The proof can be a paystub showing the premium payment taken out of your paycheck or a proof from the insurance company showing that you made premium payment.

Will KI-HIPP pay for the costs of a family plan?	KI-HIPP will pay for the cost of a family health insurance plan if it is cost-effective. This type of plan would give health insurance for the entire family, including family members who are not eligible for Medicaid.
When will my KI-HIPP benefits start?	Your KI-HIPP benefits will start the first day of the month that you applied or first day of the month after you are approved. Once you are approved, you will receive KI-HIPP Notice Of Eligibility with start date.
Are there any deductions taken from KI-HIPP premium payments?	One dollar (\$1) will be taken out of from your KI-HIPP premium payment if your employer's health insurance plan covers a non-allowable service under Medicaid. The \$1 will be taken out of your first KI-HIPP premium payment of the month. Please submit your certificate of coverage, proof of plan exclusion or plan document for us to verify that your plan does not cover any such services and \$1 will not be deducted from your KI-HIPP premium payment.
Can I set up direct deposit for KI-HIPP premium payments?	Yes, you can set up direct deposit for your KI-HIPP premium payment. To set up Direct Deposit, provide a blank check, with "void" written across the front of the check or deposit ticket that verifies your bank routing and checking account numbers. If you do not have a blank check or deposit ticket available, take KI-HIPP-63, Direct Deposit Authorization Form to the bank for completion. The KI-HIPP-63 form can be found on https://kyconnect.ky.gov/benefits/s/program-page?program=KP .

* More information on page 10-11.

* More information on page 19-20.

Step 1	Step 2	Step 3	Step 4
<p>Complete Application</p> <p>Primary Policy Holder will complete the application via:</p> <ol style="list-style-type: none"> Self-Service Portal (kynect.ky.gov/benefits) In-person to DCBS Office <p>Office 3. Over the phone calling 855-459-6328</p>	<p>Submit Documentation</p> <p>Submit required documents via:</p> <p>kynect.ky.gov/benefits</p> <ol style="list-style-type: none"> Email: KIHIPP.PROGRAM@KY.GOV Mail: CHFS, KI-HIPP Unit 275 E. Main St., 6C-A Frankfort, KY 40621 	<p>Eligibility Determination</p> <p>After you send the required documents, the KI-HIPP team will review your case and let you know if you are eligible</p>	<p>Receive Payment</p> <p>Once you are enrolled in KI-HIPP, you must do the following to get the payment:</p> <ol style="list-style-type: none"> Pay your health insurance premium Send proof of premium payment everytime you receive a notice to do so. The proof can be a paystub showing the premium payment taken out of your paycheck or a proof from the insurance company showing that you made premium payment.
<p>I was approved for KI-HIPP. When do I submit my next premium payment proof?</p> <p>To receive your ongoing KI-HIPP premium payments, you need to submit proof of premium payment every time you receive a notice to do so.</p> <p>You will get a reminder notice to submit the payment verification proof during your health plan coverage renewal period.</p> <p>For example, if your plan coverage period ends in December 2020, you will need to submit a paystub in the month of November 2020 or December 2020.</p> <p>If your household's circumstances have changed or there has been a change in your policy, you need to submit proof of the change to the KI-HIPP team as early as possible to re-evaluate your KI-HIPP benefits.</p> <p>The KI-HIPP Program performs random audits. If you do not provide the requested information by the due date, you may lose your KI-HIPP benefits. You may receive a notice to provide additional proof of premium payment if you are picked during an audit. You may receive additional correspondence from the KI-HIPP Program, please ensure that you are checking your mail or email regularly.</p> <p>You can send a paystub that shows the premium payment taken out of your paycheck or proof of payment from your insurance company through:</p> <ul style="list-style-type: none"> Self-service portal (kynect.ky.gov/benefits) Email: KIHIPP.PROGRAM@KY.GOV Mail: CHFS, KI-HIPP Unit 275 E. Main St., 6C-A Frankfort, KY 40621 			

Can I set up direct deposit for KI-HIPP premium payments?

Yes, you can set up direct deposit for your KI-HIPP premium payment. To set up Direct Deposit, provide a blank check, with "void" written across the front of the check or deposit ticket that verifies your bank routing and checking account numbers. If you do not have a blank check or deposit ticket available, take KI-HIPP-63, Direct Deposit Authorization Form to the bank for completion. The KI-HIPP-63 form can be found on <https://kynect.ky.gov/benefits/s/program-page?program=KP>.



What are my next steps?

The policy holder must complete the following steps to complete the KI-HIPP enrollment process and receive the ongoing KI-HIPP payments:

Your Next Steps	Description
<p>1 Complete KI-HIPP Application</p>	<p>Complete a KI-HIPP application via:</p> <ul style="list-style-type: none"> kynect.ky.gov In-Person (DCBS Office) Phone (855-306-8959) Email (kihipp.program@ky.gov) Mail (275 E. Main St. 6C-A, Frankfort, KY 40621)
<p>2 Submit Insurance Plan Documents</p> <p><i>*You may request these documents from your employer or insurance company.</i></p>	<p>Send the following documents* to check if the insurance plan is eligible for KI-HIPP:</p> <ul style="list-style-type: none"> Summary of Benefits and Coverage (SBC) Premium Rate Sheet
<p>3 Enroll in Employer-Sponsored Insurance (ESI)</p>	<p>After receiving a Notice of Health Insurance Plan Review, you must complete the following steps:</p> <ol style="list-style-type: none"> Enroll in the eligible ESI plan (if not already enrolled) Submit a copy of your Health Insurance Card
<p>4 Payments & Ongoing Verification</p> <p><i>*If you have (ESI), your premium payment may be automatically taken out of your paycheck.</i></p>	<p>To receive the ongoing KI-HIPP payments and stay enrolled in KI-HIPP, you must:</p> <ol style="list-style-type: none"> Pay the health insurance premium Submit proof of premium payment <u>when notified</u>

Can I set up direct deposit for KI-HIPP premium payments?

Yes, you can set up direct deposit for your KI-HIPP premium payment. To set up Direct Deposit, provide a blank check, with "void" written across the front of the check or deposit ticket that verifies your bank routing and checking account numbers. If you do not have a blank check or deposit ticket available, take KI-HIPP-63, Direct Deposit Authorization Form to the bank for completion. The KI-HIPP-63 form can be found on <https://kynect.ky.gov/benefits/s/program-page?program=KP>.

What are my next steps?

In order to receive the ongoing KI-HIPP payments that help pay for the cost of the health insurance premiums, you must submit proof of premium payment.

You must **submit one of the following documents as proof of premium payment** when you receive a **reminder notice** from the KI-HIPP Team:

- **Copy of your paystub** showing that the premium was taken out to pay for your health insurance coverage
- **Letter from your insurance company** showing the amount and the frequency that you pay for health insurance coverage

You must submit proof of premium payment when notified to show that you recently paid the premium for health insurance coverage.

You may choose one of the two options for receiving KI-HIPP payments:

Physical checks sent via mail



Payments **directly deposited** to your bank account



Complete the steps below to set up direct deposit for your KI-HIPP payments*:

Checkbook (Y/N)	Your Next Steps
<p> Yes</p> <p>(You have a checkbook or deposit ticket)</p>	<ol style="list-style-type: none"> 1 Write "Void" on the front of a blank check or deposit ticket with bank routing and checking account numbers. 2 Send blank check or deposit ticket with "Void" to the KI-HIPP Team via kynect benefits, mail, or email.
<p> No</p> <p>(You do not have a checkbook or deposit ticket)</p>	<ol style="list-style-type: none"> 1 Print KI-HIPP-63 Direct Deposit Authorization Form from this website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 2 Bring the KI-HIPP-63 Direct Deposit Authorization Form to your bank. A bank official must complete and sign the bottom of the form. 3 Send completed form to the KI-HIPP Team.

*The next steps depend on if you have a checkbook/deposit ticket or not.

Description

KI-HIPP Potential Eligibility Notice tells the individual that they may be eligible for KI-HIPP because they are enrolled in a qualifying health insurance plan as a policy holder. Additionally, this notice requests documents needed to become fully eligible.

Why am I receiving this notice?

This notice explains that you may be **eligible** for KI-HIPP because:

- ✓ You and/or family member(s) on your case are **enrolled in Medicaid** **OR** at least one member is in a **KI-HIPP eligible type of assistance (TOA)**
- ✓ You are **enrolled** in one of the following types of coverage as a policy holder:
 - Employer-Sponsored Insurance (ESI)
 - Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - Retiree Health Plan
 - United Mine Workers
- ✓ You are **NOT** currently enrolled in KI-HIPP



You must **submit the requested documents** in order to become fully eligible for KI-HIPP and receive KI-HIPP benefits.

For additional information, please visit the KI-HIPP website link below:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

KI HIPP
Kentucky Integrated Health Insurance Premium Payment

You Are Almost There! Send Us Your Documents and You Could Receive KI-HIPP Payments!

CONGRATULATIONS! the Commonwealth of Kentucky has reviewed your health insurance plan(s) shown in the table below. You are potentially eligible for the Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) program and could receive payments towards your health insurance premiums! Please keep reading to learn how you can start receiving these payments.

Source of Coverage <type of coverage>	Health Plan Name <plan name>	Primary Policy Holder Name <Policy Holder Name>

What is KI-HIPP?

KI-HIPP is a program that helps families with a Medicaid member(s) **pay for a group health insurance plan**, which is usually offered through an employer.

The KI-HIPP program sends its members payments for their share of the health insurance premium either by mailed check or direct deposit. There is more information on the KI-HIPP website!

- <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Medicaid members will NOT lose their Medicaid benefits by enrolling in the KI-HIPP program.

How can I start getting premium payments?

To start getting the premium payments, you will need to give us a copy of each of these documents

1. Your **insurance card** or a document showing proof of coverage; **AND**
2. **Proof of health insurance premium payment**. This can be one of the below documents:
 - A copy of your paystub that shows the premium was deducted to pay for the health insurance.
 - A signed letter from your insurance company on their letterhead stating the amount you paid and the month of payment for health insurance.

After you submit the necessary documents, you will receive a Notice of Eligibility explaining your results within 30 days of your application.

Where do I send this?

Upload the documents on kynect.ky.gov/benefits

Email the documents to KIHIPPPROGRAM@KY.GOV

Mail the documents to
 CHFS, KI-HIPP Unit
 275 E. Main St., 6C-A
 Frankfort KY, 40621

**** If you have questions, call us at 855-459-6328. ****

How can the KI-HIPP benefit me?

KI-HIPP program could give you additional benefits such as:

- Access to a larger network of doctors and specialists from Medicaid **AND** your private insurance
- Payments (to the Primary Policy holder) to help pay for your share of the premium
- Continued access to Medicaid benefits (to Medicaid members ONLY)

* More information on page 13.

* More information on KI-HIPP benefits can be found on page 54.

Description

KI-HIPP Potential Eligibility Notice tells the individual that they may be eligible for KI-HIPP because they are enrolled in a qualifying health insurance plan as a policy holder. Additionally, this notice requests documents needed to become fully eligible.




How can I start getting premium payments?

To start getting the premium payments, you will need to give us a copy of each of these documents

1. Your **insurance card** or a document showing proof of coverage; **AND**
2. **Proof of health insurance premium payment.** This can be one of the below documents:
 - o A copy of your paystub that shows the premium was deducted to pay for the health insurance.
 - o A signed letter from your insurance company on their letterhead stating the amount you paid and the month of payment for health insurance.

After you submit the necessary documents, you will receive a Notice of Eligibility explaining your results within 30 days of your application.

Where do I send this?

 Upload the documents on kynect.ky.gov/benefits	 Email the documents to KIHIPP.PROGRAM@KY.GOV	 Mail the documents to CHFS, KI-HIPP Unit 275 E. Main St., 6C-A Frankfort KY, 40621
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**** If you have questions, call us at 855-459-6328. ****

What are my next steps?

In order to receive the ongoing KI-HIPP payments that help pay for the cost of your health insurance premiums, you must submit the following documents:

- 1 **Proof of Enrollment:**
 - **Copy of Health Insurance Card OR Document from insurance company**
- 2 **Proof of Premium Payment:**
 - **Recent copy of your Paystub OR Letter from your insurance company**
- 3 **Summary of Benefits and Coverage (SBC)** for the appropriate benefit year plan
- 4 **Premium Rate Sheet** for the appropriate benefit year plan

Within 30 days of providing the documents, you will receive a **Notice of Eligibility** informing of your KI-HIPP eligibility results based on the documents provided.

You can send these documents to the KI-HIPP Team in one of the following ways:

Upload:
kynect.ky.gov/benefits

Mail:
 275 E. Main St., 6C-A
 Frankfort, KY 40621

Email:
kihipp.program@ky.gov

Enrolling in KI-HIPP

Description

Notice of Incomplete/Invalid Information requests more information or missing documents in order for the KI-HIPP Team to complete the processing of the KI-HIPP case.

Why did I receive this?

This notice explains that you need to send in documents because:

New KI-HIPP Applicant

You sent an application to see if you are eligible to enroll in KI-HIPP, but you did not send in all the necessary documents.



If you do not send documents, your **KI-HIPP eligibility cannot be determined.**

Existing KI-HIPP Member

You reported a change or completed recertification of eligibility, but you did not send in all the necessary documents.



If you do not send documents, you may have a **reduction or loss of benefits**

Kentucky Integrated Health Insurance Premium Payment(KI-HIPP)

Notice of Incomplete/Invalid Information

Application

<The information you have submitted is incomplete or invalid. We need further information to determine your KI-HIPP eligibility. If the information is not provided, you may not get KI-HIPP benefits.>

Change/Recertification

< The information you have submitted is incomplete or invalid. We need more information to process your KI-HIPP benefits. If the information is not provided, your KI-HIPP benefits may be changed or stopped.>

<**Required Documents**>

You may upload the documents on kynect.ky.gov/benefits, or send it to:

KI-HIPP Address: 275 E. Main St., 6C-A, Frankfort KY 40621

Email: KIHIPP.Program@ky.gov

If you have questions, call us at 855-459-6328

What are my next steps?

This section lists the specific documents that you need to send in order to complete the KI-HIPP eligibility process or continue receiving KI-HIPP benefits.

You can send these documents to the KI-HIPP Team in one of the following ways:

Upload:
kynect.ky.gov/benefits

Mail:
CHFS KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort, KY 40621

Email:
kihipp.program@ky.gov

Description

Notice of Health Insurance Plan Review tells the individual if their available ESI plan is **eligible** for KI-HIPP after each level of coverage is reviewed by the KI-HIPP Team.

To be eligible, the Employer-Sponsored Insurance Plan must be:

Cost-Effective

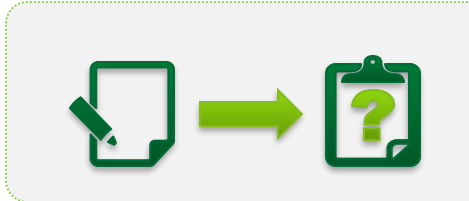
The Employer-Sponsored Insurance (ESI) plan premium, deductible, and co-pays must cost the State less than the cost to cover a member in a Managed Care Organization (MCO).

Comprehensive

An employer's insurance plan must cover at least one benefit from each of the 10 essential health benefits (EHB) categories.

Why did I receive this?

This notice explains whether your health insurance plan is eligible for KI-HIPP. You sent an application to see if you are eligible to enroll in KI-HIPP. The KI-HIPP Team sends this notice after reviewing your documents to determine your eligibility. If your ESI plan is both cost-effective and comprehensive, then you are eligible for KI-HIPP.



After review, your available health insurance plan was **determined eligible OR ineligible** for KI-HIPP enrollment.

Kentucky Integrated Health Insurance Premium Payment(KI-HIPP)

Notice of Health Insurance Plan Review

<Opening Text>
Based on the information you have submitted, the Commonwealth has completed the review of your health insurance plan(s). Please see the details below:

Source of Coverage: <type of coverage>	Health Plan Name: <plan name>
Health Plan Policy #: <policy#>	Coverage Year: <Year>

Level of Coverage	Eligible for KI-HIPP?>
<Tier>	<Yes/No>
<Tier>	<Yes/No>

<Next Steps>
If you have any questions, call us at 855-459-6328.

What are my next steps?

This section lists the next steps you must follow depending on the results of your health insurance plan review. These results vary from person to person, which means each person may have different next steps (i.e. you may need to submit additional documents to the KI-HIPP Team to complete enrollment or reapply).

Description

MCO Disenrollment Notice informs the Medicaid member of their disenrollment from a Managed Care Organization (MCO) after enrolling in KI-HIPP.

Why did I receive this?

This notice explains that the Medicaid member on the policy will no longer be covered by a Managed Care Organization (MCO). The Medicaid member will transition to traditional Medicaid in order for the KI-HIPP payments to occur.

The member will still have full access to traditional Medicaid benefits.

Enrolling in KI-HIPP provides Medicaid members two sources coverage (Employer-Sponsored Insurance (ESI) plan AND Medicaid), instead of coverage from one MCO.

Coverage of Enrolled KI-HIPP Members:



- ✗ Managed Care Organization (MCO) Coverage
- ✓ **Traditional Medicaid Coverage:** Provides you access to the full network of Medicaid benefits and providers
- ✓ **Employer-Sponsored Insurance (ESI) Coverage:** May provide you access to another set of doctors, although with potential co-pay and deductibles



MCO Disenrollment Letter		
Dear <Client Name>		
The people listed below will no longer be covered by a Managed Care Organization (MCO) after the date shown:		
Member Name	MCO	Date
<Name>	Aetna Better Health of Kentucky https://prd.chfs.ky.gov/ManagedCare/	<MMM DD, YYYY>
<Name>	Aetna Better Health of Kentucky https://prd.chfs.ky.gov/ManagedCare/	<MMM DD, YYYY>
Member Name	MCO	Date
<Name>	Aetna Better Health of Kentucky https://prd.chfs.ky.gov/ManagedCare/	<MMM DD, YYYY>
Reason: You are disenrolled from MCO because of your KI-HIPP approval, you will be moved from your Managed Care Organization (MCO) to KYHealth Choices Medicaid. You will still receive Medicaid benefits.		
<p>You got this letter based on what we know about you today.</p> <p>If this letter is hard to understand, call us at 1-855-446-1245. We can read this letter to you. We can give you free interpreter services. We can also give you this information in a way that is easier for you to read and understand.</p> <p>Para ayuda en español, llame al 1-800-635-2570. Las llamadas son gratuitas.</p> <p>Need help? Have questions? Call toll free: 1-855-446-1245. For TDD/TTY dial 711 for KY Relay Monday through Friday 8:00 a.m. to 5:00 p.m. EST</p>		



Description

MCO Disenrollment Notice informs the Medicaid member of their disenrollment from a Managed Care Organization (MCO) after enrolling in KI-HIPP.

MCO Disenrollment Letter

Dear <Client Name>

The people listed below will no longer be covered by a Managed Care Organization (MCO) after the date shown:

Member Name	MCO	Date
<Name>	Aetna Better Health of Kentucky https://prd.chfs.ky.gov/ManagedCare/	<MMM DD, YYYY>
<Name>	Aetna Better Health of Kentucky https://prd.chfs.ky.gov/ManagedCare/	<MMM DD, YYYY>

Member Name	MCO	Date
<Name>	Aetna Better Health of Kentucky https://prd.chfs.ky.gov/ManagedCare/	<MMM DD, YYYY>

Reason: You are disenrolled from MCO because of your KI-HIPP approval, you will be moved from your Managed Care Organization (MCO) to KYHealth Choices Medicaid. You will still receive Medicaid benefits.

You got this letter based on what we know about you today.

If this letter is hard to understand, call us at 1-855-446-1245. We can read this letter to you. We can give you free interpreter services. We can also give you this information in a way that is easier for you to read and understand.

Para ayuda en español, llame al 1-800-635-2570. Las llamadas son gratuitas.

Need help? Have questions? Call toll free: 1-855-446-1245.
For TDD/TTY dial 711 for KY Relay
Monday through Friday 8:00 a.m. to 5:00 p.m. EST

What are my next steps?

When paying for healthcare services or prescriptions, **the Medicaid member must provide BOTH of the following documents** to make sure the healthcare charges for services/prescriptions are billed correctly:

- 1
- Medicaid Card**
- AND**
- 2
- Health Insurance Card**

For any questions regarding your coverage and the KI-HIPP program, please call **855-459-6328**.

*For questions about MCO Disenrollment **NOT** related to KI-HIPP, call 855-446-1245.*

Description

Notice About Your KI-HIPP Coverage tells the policy holder about the outcome of eligibility determination based on information from the KI-HIPP application or a reported change.

Why did I receive this?

The KI-HIPP Notice of Eligibility provides details about your coverage and requirements based on the information entered on the KI-HIPP application or a reported change.

- This notice explains KI-HIPP eligibility, the ongoing requirements to receive KI-HIPP payments, and overall KI-HIPP coverage for members on the policy.

Section	Description
A. Coverage Summary	Members approved for KI-HIPP benefits are listed here.
B. Payment Summary	The policy holder will receive the ongoing KI-HIPP payment amount listed in this section. The dollar amount of KI-HIPP payments are based on the premium shown on the paystubs submitted by the policy holder.
C. Members who had their KI-HIPP coverage end	Members who have been disenrolled from KI-HIPP are listed here along with the reason for disenrollment.
D. Who was denied for KI-HIPP coverage	Members who have been denied KI-HIPP coverage are listed here along with the reason for denial.

Notice About Your KI-HIPP Coverage

Congratulations! Your case has been approved for KI-HIPP based on the information reported. Please see below for your household coverage and requirement(s):

Please see below for your household coverage and requirement(s):

A Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Coverage Summary

Name	Policy ID	Effective Begin Date	Effective End Date	Primary Policy Holder Name
<Covered Individuals>	<Policy ID>	<MMM DD, YYYY>	<MMM DD, YYYY>	<Primary Policy Holder Name >

KI-HIPP Information: The Primary Policy Holder will receive a premium payment to help pay the health insurance premium. Submit proof of premium payment every time you receive a notice to do so. However, if your household's circumstances have changed or there has been a change in your policy, you need to submit the premium payment proof to KI-HIPP team as early as possible to re-evaluate your KI-HIPP benefits. See the KI-HIPP Program Information page for more information. If you have any questions, please call 855-459-6328.

B KI-HIPP Payment Summary

Primary Policy Holder Name	Policy ID	Effective Begin Date	Effective End Date	Approved Amount	Level of Coverage
<Primary Policy Holder Name>	<Policy ID >	<MMM DD, YYYY>	<MMM DD, YYYY>	\$<Premium Amount>	<tier>

The table above shows your KI-HIPP eligible monthly approved amount for the level of coverage. You will receive premium payment for the amount you pay to your insurance based on the premium payment proof you give us. See the KI-HIPP Program Information page for more information on how monthly payment amount is calculated. If you have any questions, please call 855-459-6328.

C Members who had their KI-HIPP coverage end

Name	Policy ID	Effective Date	Termination Reason
<Covered Individuals>	<Policy ID>	<MMM DD, YYYY> – <MMM DD, YYYY>	You will no longer receive KI-HIPP benefits because <Individual Termination Reason>. We based our decision on the rules in: <Rules Reg >

D Who was denied for KI-HIPP coverage

Name	Policy ID	Denial Effective Date	Denial Reason
<Covered Individuals>	<Policy ID>	<MMM DD, YYYY> – <MMM DD, YYYY>	You will not receive KI-HIPP benefits because <Individual Denial Reason>. We based our decision on the rules in: <Rules Reg >
<Covered Individuals>	<Policy ID>	<MMM DD, YYYY>	You will not receive KI-HIPP benefits because <Individual Denial Reason>. We based our decision on the rules in: <Rules Reg >

*** If your household's circumstances have changed or you have questions, call us at 855-459-6328. You may also report changes by logging in to the Self-Service Portal at <https://kynect.ky.gov/benefits> or you may visit a Department for Community Based Services (DCBS) Office. To find a DCBS office near you go to https://prdweb.chfs.ky.gov/Office_Phone/index.aspx.**

If you want legal help, you may get free legal help from your local legal aid office at 1-800-782-1924.

Description

Notice About Your KI-HIPP Coverage tells the policy holder about the outcome of eligibility determination based on information from the KI-HIPP application or a reported change.

Members who had their KI-HIPP coverage end			
Name	Policy ID	Effective Date	Termination Reason
<Covered Individuals>	<Policy ID>	<MMM DD, YYYY> – <MMM DD, YYYY>	You will no longer receive KI-HIPP benefits because <Individual Termination Reason>. We based our decision on the rules in: <Rules Reg.>

Who was denied for KI-HIPP coverage			
Name	Policy ID	Denial Effective Date	Denial Reason
< Covered Individuals>	<Policy ID>	<MMM DD, YYYY> – <MMM DD, YYYY>	You will not receive KI-HIPP benefits because <Individual Denial Reason>. We based our decision on the rules in: <Rules Reg.>
< Covered Individuals>	<Policy ID>	<MMM DD, YYYY>	You will not receive KI-HIPP benefits because <Individual Denial Reason>. We based our decision on the rules in: <Rules Reg.>

If your household’s circumstances have changed or you have questions, call us at 855-459-6328. You may also report changes by logging in to the Self-Service Portal at <https://kynect.ky.gov/benefits> or you may visit a Department for Community Based Services (DCBS) Office. To find a DCBS office near you go to https://prdweb.chfs.ky.gov/Office_Phone/index.aspx.

If you want legal help, you may get free legal help from your local legal aid office at 1-800-782-1924.

What are my next steps?

If your household’s circumstances have changed, you must **report a change** via:



- Visit kynect benefits: kynect.ky.gov/benefits
- Visit Dept. for Community Based Services (DCBS) Office
- Contact DCBS: **855-306-8959**

You must “report a change” if any of the changes below apply:

Income	Employer	Health Plan
Household Size	Address	Tax Filing Status

For any questions about your KI-HIPP coverage, please call 855-459-6328. For legal help, please call your local legal aid office.

Description

KI-HIPP Notice of Eligibility Insert provides more information about the KI-HIPP program to the policy holder if at least one member is getting KI-HIPP benefits.

Why did I receive this?

The KI-HIPP Notice of Eligibility insert is sent with the Notice of Eligibility when there is at least one member on your policy who is actively enrolled in KI-HIPP.

This insert provides more information about the following topics:

Topic	Description
KI-HIPP Payments	<p>You must submit proof of premium payment when notified in order to receive KI-HIPP payments to help pay for the cost of premiums.</p> <p>If you do not submit proof of premium payment by the due date listed on the notice, you may be disenrolled from KI-HIPP (i.e. you will no longer receive KI-HIPP payments).</p> <p>If the ESI plan covers elective abortion, one dollar (\$1) will be taken out of the first KI-HIPP payment the policy holder receives each month. If the policy holder submits insurance plan documents that verify elective abortion (EA) is NOT COVERED, they will receive the full KI-HIPP payment every time. The following page outlines the necessary documents and steps needed to verify EA information.</p>
Good Cause	<p>You may receive KI-HIPP payments for late submissions if you provide proof of "good cause" (i.e. the reason that you did not submit proof of premium payment by the due date).</p>

Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Information

How do KI-HIPP payments work?	As a KI-HIPP member, you get payments for the cost of premiums for a group health insurance plan.
How do I set up a direct deposit to get KI-HIPP payments?	To set up Direct Deposit, provide a blank check, with "void" written across the front of the check or deposit ticket that verifies your bank routing and checking account numbers. If you do not have a blank check or deposit ticket available, take KI-HIPP-63, Direct Deposit Authorization Form to the bank for completion. The KI-HIPP-63 form can be found on https://kynect.ky.gov/benefits/s/program-page?program=KP .
How can I get payments regularly?	<p>To receive your ongoing KI-HIPP premium payments, send us proof of premium payment every time you receive a notice to do so. The proof can be a paystub showing the premium payment taken out of your paycheck or a proof from insurance company showing that you made premium payment.</p> <p>You will get a reminder notice to submit the payment verification proof twice during your health plan coverage period. For example, if your plan coverage period ends in December 2020, you will need to submit a paystub in the month of May 2020 and November 2020.</p> <p>You can send a paystub or proof of payment from your insurance company through:</p> <ul style="list-style-type: none"> • Upload the documents on kynect.ky.gov/benefits; or • Email KIHIPP.PROGRAM@KY.GOV; or • Mail : CHFS, KI-HIPP Unit 275 E. Main St., 6C-A Frankfort, KY 40621 <p>The online Self-Service Portal (kynect.ky.gov/benefits) is the fastest way to send your proof of payment.</p>
What happens if I do not send my paystub or proof of payment?	You will receive a reminder notice to submit your next premium payment proof. If you do not send proof of payments within the time shown on the notice, you may lose KI-HIPP benefits as your KI-HIPP case will close. Medicaid members may not lose their Medicaid benefits.

Description

KI-HIPP Notice of Eligibility Insert provides more information about the KI-HIPP program to the policy holder if at least one member is getting KI-HIPP benefits.

What are my next steps?

Topic	Your Next Steps
<p>How do I give proof of “good cause”?</p>	<p>To give proof of good cause, upload documents supporting your good cause reason at kynect.ky.gov/benefits by selecting document type as “KI-HIPP Good Cause”.</p>
<p>Are there any deductions taken from KI-HIPP premium payments?</p>	<p>One dollar (\$1) will be taken out of from your KI-HIPP premium payment if your employer’s health insurance plan covers a non-allowable service under Medicaid. The \$1 will be taken out of your first KI-HIPP premium payment of the month. Please submit your certificate of coverage, proof of plan exclusion or plan document for us to verify that your plan does not cover any such services and \$1 will not be deducted from your KI-HIPP premium payment.</p>
<p>Do I need to report changes?</p>	<p>Any time there is a change to your insurance plan, you must report the changes on kynect.ky.gov/benefits or call the KI-HIPP Call Center at 855-459-6328.</p> <p>Examples of changes that you must report are:</p> <ul style="list-style-type: none"> • Loss of health plan for any reason • Changes to the cost of the premium for your plan • Adding or removing people from your plan <p>The plan benefits and cost may change year to year, even if you do nothing. You must also report these changes as soon as you find out. These changes take place during the “Open Enrollment” period.</p> <p>It is important that you report any changes as soon as possible. If you do not report changes to your plan, you may stop getting KI-HIPP benefits or have a break in your payments.</p>

Description

KI-HIPP Application Summary is used to collect an official signature from the policy holder and provides a summary of information from their KI-HIPP application.

Why did I receive this?

The KI-HIPP Application is sent to the policy holder after completion of the KI-HIPP application. This notice is used to collect an official signature from the policy holder.

This notice provides a summary of the following application details:

- Policy Holder Contact Information (Name, Phone Number, Address)
- Correspondence Preference (Email, Text, or Mail)
- Members Covered by KI-HIPP
- Health Insurance Plan Information

<Client First MI Last Name >
<Care of (c/o) >
<To Street Address Line 1 >
<To Street Address Line 2 >
<To City, State, Zip >

KI-HIPP Application Summary

This is a summary of information given by you for your Health Insurance Policy and covered individuals. If you are eligible for KI-HIPP you will get another notice with coverage details.

Applicant <First Name> <Middle Name> <Last Name> <Suffix>	Primary Phone Number <Phone Number>
Physical Address <Physical Address Line 1> <Physical Address Line 2> <Physical City> <Physical County> <Physical State> <Physical Zip>	Mailing Address <Mailing Address Line 1> <Mailing Address Line 2> <Mailing City> <Mailing County> <Mailing State> <Mailing Zip>
Authorized Representative <AR First M. Last Name> <AR Address Line 1> <AR Address Line 2> <AR City, St, Zip> <Phone Number>	

Correspondence Preferences

Notify me of a new message in my message center by:	<Correspondence Preference 1>
E-mail:	<Email>
Send text messages alerts to my primary phone number:	<Correspondence Preference 2>
Send text message alerts to my secondary phone number:	<Correspondence Preferences 3>
Paper Notification:	<Paper Notification>

Website: <http://chfs.ky.gov> 1 An Equal Opportunity Employer M/F/D

* The rest of the document is on page 24.

Description

KI-HIPP Application Summary is used to collect an official signature from the policy holder and provides a summary of information from their KI-HIPP application.

<p>my KI-HIPP worker within 30 days from the day I become aware of the change.</p> <p>I understand if Medicaid provides me services in a Home and Community Based Waiver Services Program as an alternative to care in a Nursing Facility or Intermediate Care Facility for the intellectually disabled my estate will be subject to recoupment of the monies expended on my behalf at my death for services received during the period of institutionalization.</p> <p>I understand that my medical records, which are maintained by the medical providers who provide services to me, may be reviewed and copied by authorized state and federal government benefits auditors or investigators or those so authorized.</p> <p>I declare that all persons for whom application is made are U.S. citizens or are admitted under an approved alien status. I certify, under penalty of perjury, the information, including citizenship or alien status, provided by me in this statement is correct and true to the best of my knowledge. I hereby give my consent to the Department for Medicaid Services and the Office of the Inspector General to make necessary contact to verify statements made by me in this application.</p> <p>I understand that if I receive Medicaid benefits and I am found guilty of committing a Medicaid intentional program violation (MA IPV), I may be subject to penalties that include disqualification from the Medicaid program for up to one year and repayment of the Medicaid benefits received during that time the IPV occurred. An IPV occurs when it is determined that a Medicaid recipient or responsible party made a false or misleading statement, or misrepresented, concealed, or withheld facts in order to receive services through the Medicaid program to which they were otherwise not entitled, or allowed someone else to use their MA card. Any suspected criminal activity will be referred to the appropriate legal authorities for further investigation and possible legal action. Criminal action can be taken against a recipient at any time and shall be handled separately from any administrative action proposed by the Department for Medicaid Services.</p> <p>DO NOT give false information or conceal information to receive or to continue to receive Medicaid benefits. DO NOT let someone else use your Medicaid card. DO NOT abuse Medicaid benefits.</p> <p>I understand if I give false information, withhold information or fail to report changes within 30 days, or allow someone else to use my MA card, I may be prosecuted for fraud, lose Medicaid benefits, and be required to repay benefits I received.</p> <p>I understand that I must cooperate with Quality Control (QC). QC is a part of DCBS. QC reviews cases to make sure we determine who can get help correctly.</p> <p>Your Signature _____ Today's Date _____</p> <p>Spouse's Signature _____ Today's Date _____</p> <p>Website: http://chfs.ky.gov 3 An Equal Opportunity Employer M/F/D</p>	<p>Witness, if you signed with an X _____</p> <p>_____ Today's Date _____</p> <p>All Applications for assistance are considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.</p> <p>You or your representative may request a fair hearing either orally or in writing if you disagree with any action taken in your case. Your case may be presented at the hearing by any person you choose.</p> <p>A fair hearing may be requested by contacting a local office or Call Services at 1-855-306-8959, or by sending a letter to: Cabinet for Health and Family Services Division of Administrative Hearings, Families and Children Administrative Hearings Branch 105 Sea Hero Rd, Suite 2 Frankfort, KY 40601</p> <p>Website: http://chfs.ky.gov 4 An Equal Opportunity Employer M/F/D</p>
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What are my next steps?



1. **Read** the *Rights, Responsibilities, and Signature Warning Penalty**
2. **Sign your name** on the *Your Signature* line
3. Enter **today's date** on the *Today's Date* line



If any of the application information is incorrect, please call **855-459-6328**.
If you disagree with actions on your case, call **855-306-8959** to request a hearing.

*Please Note: This is an abridged version of the *Rights, Responsibilities, and Signature Warning Penalty*.

Description

Did You Know Notice provides information on the ways that members may receive help from the Department of Community Based Services (DCBS) with any program activity.

Why did I receive this?

This notice outlines the Americans with Disabilities Act (ADA). Members with any kind of health problem* have the right to receive help from the Department of Community Based Services (DCBS) when applying for programs and keeping benefits.

***Please Note:** Members do **not** have to get disability benefits to receive help from DCBS.

DCBS may provide help to members in the following ways:

- Filling out program applications
- Keeping appointments via phone calls or reminders
- Understanding notices/letters you received

DCBS may help you and/or your family in several other ways listed on the notice.

DID YOU KNOW?

If you have a physical or mental problem that makes it hard for you to:

- Apply for financial assistance (known as K-TAP), Medicaid, food assistance (known as SNAP), KI-HIPP or other benefits.
- Keep appointments with us.
- Do a task or activity we ask you to do.

We can help.

If you have a physical or mental problem, tell a worker so he/she can help you. We can also help you if you care for a family member and that makes it hard for you to get benefits. This flyer tells you why and how we can help.

Americans with Disabilities Act (ADA)

The law: You have the right under the Americans with Disabilities Act (ADA) to get help applying for and keeping benefits. You can get help with any activity needed to use our programs.

Who it protects: You have rights under the ADA if any kind of health problem makes it hard for you to do something basic and important, like:

- care for yourself
- walk, stand, or sit
- see, hear, or talk
- breathe
- learn
- remember things
- do tasks with your hands
- work

The problem can be physical, like diabetes, asthma, or migraine headaches. Or it can be mental or emotional, like depression, anxiety, or attention deficit/hyperactivity disorder (ADHD). It can also be a learning disability, like dyslexia.

You do not have to get disability benefits to get this help.

How we can help: If you have one or more of these problems, you have the right to get help from a DCBS worker. Depending on the nature of your health problem, this help may include:

- Help filling out applications and getting information and papers we ask you to give us;
- Home visits or telephone interviews if you are unable to come to our office;
- Phone calls or notices to remind you of appointments or to return needed information and papers;
- A meeting space big enough for medical equipment you need, like a walker, wheelchair, oxygen tank, etc.
- Help understanding what the letters we send you mean;
- More time to do work activities;
- Permission from us not to do work activities;
- Help finding a work activity you can do;
- Services to help you get ready to do a work activity;
- Help filing an ADA grievance if you believe you did not get the help you needed;
- Other types of help.

Description

Did You Know Notice provides information on the ways that members may receive help from the Department of Community Based Services (DCBS) with any program activity.

If you need help due to a physical or mental problem, tell a worker what you need in order to access benefits and services offered by the Department for Community Based Services.

If you do not get the help you ask for, you may file an ADA grievance by telephone, mail, or fax to:

Cabinet for Health and Family Services
Office of Human Resource Management
EEO Compliance Branch
275 E Main St 5C-D
Frankfort, KY 40621
Phone 502-564-7770, ext. 4107
FAX 502-564-3129

"In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.
Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs."

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 1-866-632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW,
Washington DC 20250-9410;

(2) fax: 202-690-7442; or

(3) [email: program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

What are my next steps?



If you and/or a family member need help due to a physical or mental problem, **please ask a DCBS worker for help** in order to access benefits and services offered by DCBS.

If you do not get the help you ask for, you may file an ADA grievance to the Cabinet for Health and Family Services Office of Human Resource Management EEO Compliance:

- Mail: 275 E Main St. 5C-D Frankfort, KY 40621
- Phone: 502-564-7770, ext. 4107
- Fax: 502-564-3129

Description

Notice of Privacy Practices provides information about your privacy rights as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Why did I receive this?

This notice describes how medical information about you may be used and disclosed by the Department for Medical Services (DMS) and your privacy rights.

This notice provides more information on the following topics:



- How your protected health information may be given out to carry out treatment, payment, or healthcare operations
- Your privacy rights regarding the access of your Medicaid health information
- How DMS protects your health information

MAP-065
(4/14/03)

Cabinet for Health and Family Services
Department for Medicaid Services

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHAT IS THIS NOTICE?

This *Notice of Privacy Practices* is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. *This notice tells you:*

- How the Department for Medicaid Services (DMS) and its contracted business partners may use and give out your protected health information to carry out treatment, payment or healthcare operations and for other purposes permitted/ required by law.
- What YOUR rights are regarding the access of your Medicaid health information.
- How DMS protects your health information.

OUR DUTY TO PROTECT YOUR PRIVACY

Your health information is personal. DMS is legally required to protect the privacy of your data. It does so in all aspects of its business. DMS has policies about protecting the privacy of your data. *These policies comply with State and Federal laws.* DMS uses and gives out your health information only where required by law or where necessary for business.

WHERE DO I SEND QUESTIONS OR REQUESTS?

To submit questions about your privacy rights or to submit a written request to DMS about your privacy rights, contact the DMS Privacy Officer at:

Cabinet for Health and Family Services
Department for Medicaid Services
275 E. Main Street
Frankfort KY 40621

Or, you may contact DMS by dialing 1-800-635-2570. *If you have a hearing impairment, you may call the TDD/TTY number at 1-800-773-0296.*

WHAT TYPES OF INFORMATION DOES DMS HAVE?

The Department for Community Based Services (DCBS) or Social Security Administration (SSA) for Supplemental Security Income (SSI) approved you for Medicaid. DCBS and SSA send your information to DMS. DMS then pays your providers for claims they send in. Information sent to DMS includes:

- Your individual information including: name, address, phone number, date of birth, social security number, eligibility program information, and Medicaid number.
- Information on other health insurance policies you may have
- Your Medical Records (*when necessary*)
- Your provider's claims for your services. Provider claims contain information on your treatment given and may include x-rays and lab results.

All this information is considered to be your Protected Health Information (PHI).

What are my next steps?

You have the right to receive a paper copy of the full 7-page Notice of Privacy Right*.

You may receive a paper copy in one of the following ways:

- Mail a written request to: Cabinet for Health and Family Services Department of Medicaid Services 275 E. Main Street, Frankfort, KY 40621
- Search "Notice of Privacy Practices" on chfs.ky.gov



For any questions about your privacy rights, please call **1-800-635-2570**.

*Please Note: This is an abridged version of the Notice of Privacy Rights.

**Reminders for
Enrolled KI-HIPP
Members**

Description

Notice of Health Insurance Plan Review tells the enrolled KI-HIPP if their reported level of coverage is eligible for KI-HIPP after each level of coverage is reviewed.

Why did I receive this?

This notice explains that your reported (new) level of coverage is **not** eligible for KI-HIPP. You reported a change in your plan's level of coverage which caused your case to be re-reviewed for KI-HIPP eligibility. After review, the new level of coverage was determined ineligible for KI-HIPP. Therefore, you will continue your KI-HIPP enrollment in your current level of coverage and receive your current KI-HIPP payments.

Example: You enrolled in KI-HIPP with the "Employee Only" level of coverage. You recently reported a change in your level of coverage to "Employee Plus Spouse", which is not eligible for KI-HIPP. Since the new level of coverage is ineligible for KI-HIPP, the following occur:

- You will **not** receive KI-HIPP payments to help pay for the "Employee Plus Spouse"
- You will continue KI-HIPP enrollment with current level of coverage ("Employee Only")
- You will receive the same amount in KI-HIPP payments that you are currently receiving to help pay for the cost for your "Employee Only" level of coverage.

The **new level of coverage** was determined **ineligible** for KI-HIPP.
 You will continue KI-HIPP enrollment with your **current level of coverage**.
 You will receive the **same KI-HIPP payments** that you currently receive to help pay for the cost of your current level of coverage.



Notice of Health Insurance Plan Review

Based on the information you have submitted, the Commonwealth has completed the review of your health insurance plan(s). Please see the details below:

Source of Coverage: <type of coverage>	Health Plan Name: <plan name>
Health Plan Policy #: <policy#>	Coverage Year: <Year>
Level of Coverage	Eligible for KI-HIPP?>
<New level of coverage>	No

Your above plan level of coverage is not eligible for KI-HIPP. You will continue your current KI-HIPP enrollment in <current level of coverage> coverage and will continue to receive current KI-HIPP benefits.

If you have any questions, call us at 855-459-6328.

What are my next steps?



You do not have to do anything else. You will continue your current level of coverage that is eligible for KI-HIPP and receive the same KI-HIPP payments.

Description

Notice of Action: Submit Premium Payment Proof requests the most recent proof of premium payment to verify employment or health insurance from in order for the enrolled KI-HIPP member to stay enrolled and continue receiving the ongoing KI-HIPP payments.

Why did I receive this?

This notice explains that the system detected a potential loss of employment and/or health insurance. You may **not** receive the KI-HIPP payments that help pay the cost of the health insurance premiums until you **submit the most recent proof that you paid the premium for health insurance coverage**.

If you do NOT submit **recent proof of premium payment** by the **end of next month**:



You may **NOT** receive the ongoing KI-HIPP **payments** after next month unless you submit proof that you are still enrolled in your health insurance plan and recently paid the premium for health insurance coverage.



Notice to Submit Premium Payment Proof

Our sources show that your employment or insurance may have ended. Submit your most recent proof that you paid your health insurance premium.

If you do not provide your premium payment proof by **<next month end>**, you may not get your KI-HIPP premium reimbursement starting **<Next month + 1 (MMM) Year>**.

You can use any of the following as proof of payment:

- A copy of your paystub that shows the premium was deducted to pay for your health insurance; or
- A letter or a receipt from your insurance company stating your current payment and how often you pay.

Please give us your most recent proof of premium payments by **<next month end>** 4:00 p.m. EST. You may upload the documents on kynect.ky.gov/benefits, or send it to:

KI-HIPP Address: CHFS KI-HIPP Unit 275 E. Main St., 6C-A, Frankfort, KY 40621

Email: KIHIPP.PROGRAM@KY.GOV

If you have questions, call us at 855-459-6328

Tear here and return the bottom portion with a **copy** of your document if you are sending it via mail, email or fax.

KI-HIPP Submit to Provide Premium Payment Proof

NAME: <Client First MI Last Name>

CASE NUMBER: <Case Number>

Description

Notice of Action: Submit Premium Payment Proof requests the most recent proof of premium payment to verify employment or health insurance in order for the enrolled KI-HIPP member to continue receiving the ongoing KI-HIPP payments.



Notice to Submit Premium Payment Proof

Our sources show that your employment or insurance may have ended. Submit your most recent proof that you paid your health insurance premium.

If you do not provide your premium payment proof by **<next month end>**, you may not get your KI-HIPP premium reimbursement starting **<Next month + 1 (MMM) Year>**.

You can use any of the following as proof of payment:

- A copy of your paystub that shows the premium was deducted to pay for your health insurance; or
- A letter or a receipt from your insurance company stating your current payment and how often you pay.

Please give us your most recent proof of premium payments by **<next month end>** 4:00 p.m. EST. You may upload the documents on kynect.ky.gov/benefits, or send it to:

KI-HIPP Address: CHFS KI-HIPP Unit 275 E. Main St., 6C-A, Frankfort, KY 40621

Email: KIHIPP.PROGRAM@KY.GOV

If you have questions, call us at 855-459-6328

Tear here and return the bottom portion with a **copy** of your document if you are sending it via mail, email or fax.

KI-HIPP Submit to Provide Premium Payment Proof

NAME: <Client First MI Last Name>

CASE NUMBER: <Case Number>

What are my next steps?

You must **submit one of the following documents as recent proof of premium payment** to the KI-HIPP Team by **4:00 PM** by the **end of the month due date** listed:

- **Copy of your paystub** showing that the premium was recently deducted to pay for health insurance coverage
- **Letter from your insurance company** showing the amount and the frequency that you pay for health insurance coverage

You may submit a **copy of your paystub** or **letter from your insurance company** as premium payment proof to the KI-HIPP Team in one of the following ways:

Upload:
kynect.ky.gov/benefits

Mail:
275 E. Main St., 6C-A
Frankfort, KY 40621

Email:
kihipp.program@ky.gov

Please Note: If you send the document via **mail** or **email** you must **include** the bottom section of this notice (**see dotted line**).


Description

Notice of Premium Change requests that the enrolled KI-HIPP member report the reason for a change in their health insurance premium amount.

Why did I receive this?

This notice explains that you must report a change because the premium amount on your most recent proof of premium payment has changed (**increased or decreased**) from your previous proof of premium payment.

Example: After receiving a reminder notice, you submitted a paystub showing that \$50 was taken out to pay for your premium for the Plan Midpoint Date (i.e. usually 6 months before the end of the health insurance plan coverage period). At Plan End Date (i.e. the end of the health plan coverage period) you submitted a paystub with \$75 taken out to pay for your premium.



This notice asks you to report **why** your health insurance premium amount has changed from previous months.



Notice of Premium Change

The health insurance premium on your proof of payment for <Month, Year> was different from your last payment proof. You must report the reason(s) for the change with supporting documents.

If people were added or removed from your plan, give us:	<ul style="list-style-type: none"> A copy of your insurance card; or A document from the insurance company showing the change in coverage.
If your benefits changed , give us:	<ul style="list-style-type: none"> A copy of your Summary of Benefits and Coverage (SBC). You can ask for a copy from your insurance company or employer at any time.
If your plan changed , give us:	<ul style="list-style-type: none"> Information about your new plan. <ol style="list-style-type: none"> Log in to kynect.ky.gov/benefits to update your information online; or Complete the Health Coverage form with the updated information. You may get a copy of the Health Coverage form from: <ul style="list-style-type: none"> Self Service Portal https://kynect.ky.gov/benefits/s/program-page?program=KP; or A Department of Community Based Services (DCBS) office. To find a DCBS office near you go to https://prdweb.chfs.ky.gov/Office_Phone/index.aspx.

Please give us the above information no later than <Due Date> 4:30 p.m. EST. You may upload the documents on kynect.ky.gov/benefits, or send them to:

KI-HIPP Address: CHFS, KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort, KY 40621

Email: KIHIPP.PROGRAM@KY.GOV

If you have questions, call us at 855-459-6328

Tear here and return the bottom portion with a copy of your document if you are sending it via mail or email.

KI-HIPP Notice of Premium Change

NAME: <FIRST LAST> CASE NUMBER: <Case Number>

* More information on page 33.

Description

Notice of Renewal requests recent proof of premium payment and enrollment documents for the upcoming year's health insurance plan from the enrolled KI-HIPP member. KI-HIPP members receive this notice 30 days before their current health plan coverage ends.

Why did I receive this?

This notice explains that you must renew your KI-HIPP benefits because your current health insurance plan coverage period is ending soon (i.e. your Plan End Date is in 30 days). Additionally, you received this notice for one of the following reasons:

- 1 Your Medicaid Renewal Date is different from your KI-HIPP Renewal Date; OR
- 2 Your case was selected for Medicaid Passive Renewal
- 3 Your case was selected for Active Renewal; however, the KI-HIPP policy holder is not the Head of Household (HoH)

You must submit recent proof of premium payment and enrollment documents for the upcoming year's health plan by the Plan End Due Date listed on the notice in order to stay enrolled in KI-HIPP and continue receiving the ongoing KI-HIPP payments.

*If you do **NOT** submit enrollment documents for the upcoming year by the Plan End Date:*



You will **NOT** get the KI-HIPP **payment** after your current plan coverage ends



You will be **disenrolled from KI-HIPP** by the Plan End Date



WE NEED INFORMATION TO RENEW YOUR KI-HIPP BENEFITS

Why?

It's time to renew your KI-HIPP benefits. We cannot renew them unless you give us the information we ask for in this letter. **If we do not get it, we may have to stop your KI-HIPP payments.**

What's Next? We need you to submit proof.

Proof We Require	Examples of Proof	Due Date
Proof you paid your premiums	<ul style="list-style-type: none"> • A paystub showing your premium was taken out of your pay for the month of <Plan end date -1 month, year> or <Plan end date month, year>; or • A statement from your insurance company showing you made premium payments for the month of <Plan end date -1 month, year> or <Plan end date month, year>. 	4:00pm ET on <Plan end date>
Proof of what your plan will cover next benefit year	Your insurance company's Summary of Benefits and Coverage (SBC) for your next benefit year	4:00pm ET on <Plan end date>
Proof of the amount of your monthly premium	Your insurance company's Premium Rate Sheet for the next benefit year	4:00pm ET on <Plan end date>
Proof of changes	<ul style="list-style-type: none"> • A copy of your insurance card; and • A document from your insurance company to verify any changes in health plans, coverage, household membership 	4:00pm ET on <Plan end date>



* More information on page 35.

Description

Notice of Renewal requests recent proof of premium payment and enrollment documents for the upcoming year's health insurance plan from the enrolled KI-HIPP member. KI-HIPP members receive this notice 30-60 days before their current health plan coverage ends.

How?

Here's what you need to do:

- **Gather** all the proof(s) we require.
- **Submit** proof(s) to us by the due dates above. You can
 - **Upload** the documents on our Self-Service Portal (<https://kynect.ky.gov/benefits>), **or**
 - Email the documents to <KI-HIPP email>, **or**
 - **Mail** the documents to:
<KI-HIPP return address>

Need help?

If you need help collecting the things we ask for, please call <KI-HIPP Call Center Number>. You have a right to get help from us.

If you want legal help, you may be able to get free legal help from your local legal aid office at <Legal Aid Office Number>.

What if your benefits stop?

If you do not submit these documents in time, your KI-HIPP benefits may stop. This means the policy holder will no longer receive premium payments and will be responsible to pay for the employer-sponsored insurance (ESI) plan.

For Medicaid members previously enrolled in an MCO, the Medicaid member will transition out of the KI-HIPP program and back to an MCO if KI-HIPP benefits stop.

A KI-HIPP member can reapply for benefits at any time by calling <KI-HIPP Call Center Number> or sending an email to <KI-HIPP email>.

What are my next steps?

You must **submit each of the following documents for your health plan in the upcoming year** to the KI-HIPP Team by **4:00 PM** by the **Plan End Due Date** listed:

- 1 **Proof of Premium Payment** showing that you recently paid the premium for health insurance coverage *before or during the month of the Plan End Date*
 - **Recent copy of your Paystub OR Letter from your insurance company**
- 2 **Summary of Benefits and Coverage (SBC)** for the upcoming benefit year plan
- 3 **Premium Rate Sheet** for the upcoming benefit year plan
- 4 **Proof of Changes in Enrollment** showing changes for the health plan (if applicable)
 - Copy of **Health Insurance Card OR Document from insurance company**

You can send these documents to the KI-HIPP Team in one of the following ways:

Upload:
kynect.ky.gov/benefits

Mail:
275 E. Main St., 6C-A
Frankfort, KY 40621

Email:
kihipp.program@ky.gov

Description

Renewal Reminder Notice reminds KI-HIPP members to send recent proof of premium payment and enrollment documents for upcoming year's health plan. KI-HIPP members get this notice on the 15th of the month of the Plan End Date for the current plan.

Why did I receive this?

This notice explains that you did **not** submit proof of premium payment and enrollment documents for the upcoming year's health plan by the 15th of the Plan End Date month.

You must submit recent proof of premium payment and enrollment documents for the upcoming year's health plan by the Plan End Due Date to **stay enrolled in KI-HIPP**.

Example: If your current health plan ends on 12/31/2020 (Plan End Date), you must submit enrollment documents for your 2021 health plan by the Plan End Date. If you do **not** submit 2021 enrollment documents, **you will be disenrolled from KI-HIPP on 12/31/2020**.

If you do **NOT** send premium payment proof by the Plan End Due Date listed:



You will **not** get the KI-HIPP **payment** after the Plan End Date

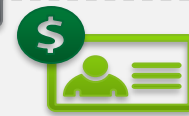


You will be **disenrolled from KI-HIPP** by the Plan End Date

If you are **disenrolled** from KI-HIPP:



Medicaid member(s) previously in an MCO are **re-enrolled** in an MCO



You **may have to pay your premiums** *without* KI-HIPP payments to help you pay

Renewal Reminder Notice

We have not received your premium payment verification proof or documents for your next plan year benefits.

If you do not give us your proof on time, you may not get your KI-HIPP payments starting next month and you may lose your KI-HIPP benefits.

You must submit the below information:

- A paystub showing the premium payment taken out of your paycheck or a proof from insurance company showing that you made premium payment,
- Summary of Benefits and Coverage (SBC) for the next benefit year,
- Premium Rate Sheet for the next benefit year, and
- Proof of changes in enrollment, if your enrollment has changed. This can be a copy of your insurance card or a document from the insurance company.



Description

Renewal Reminder Notice reminds KI-HIPP members to send recent proof of premium payment and enrollment documents for upcoming year's health plan. KI-HIPP members get this notice on the 15th of the month of the Plan End Date for the current plan.

Renewal Reminder Notice

We have not received your premium payment verification proof or documents for your next plan year benefits.

If you do not give us your proof on time, you may not get your KI-HIPP premium payments starting next month and you may lose your KI-HIPP benefits.

You must submit the below information:

- A paystub showing the premium payment taken out of your paycheck or a proof from insurance company showing that you made premium payment,
- Summary of Benefits and Coverage (SBC) for the next benefit year,
- Premium rate sheet for the next benefit year, and
- Proof of changes in enrollment, if your enrollment has changed. This can be a copy of your insurance card or a document from the insurance company.

Please submit the above information by **<Plan End Date>** 4:00 p.m. EST. You may upload the documents on kynect.ky.gov/benefits, or send it to:

KI-HIPP Address: CHFS, KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort, KY

Email: KIHIPP.PROGRAM@KY.GOV

If you have questions, call us at 855-459-6328.

Tear here and return the bottom portion with a **copy** of your document if you are sending it via mail or email.

KI-HIPP Renewal Reminder Notice

NAME: **<Client First MI Last Name>** CASE NUMBER: **<Case Number>**

What are my next steps?

You must **submit each of the following documents for your health plan in the upcoming year** to the KI-HIPP Team by **4:00 PM** by the **Plan End Due Date** listed:

- 1 **Proof of Premium Payment** showing that you recently paid the premium for health insurance coverage *before or during the month of the Plan End Date*
 - **Recent copy of your Paystub OR Letter from your insurance company**
- 2 **Summary of Benefits and Coverage (SBC)** for the upcoming benefit year plan
- 3 **Premium Rate Sheet** for the upcoming benefit year plan
- 4 **Proof of Changes in Enrollment** showing changes for the health plan (if applicable)
 - Copy of **Health Insurance Card OR Document from insurance company**

You can send documents to the KI-HIPP Team in one of the following ways:

Upload:
kynect.ky.gov/benefits

Mail: KI-HIPP Address

Email: KI-HIPP Team



Please Note: If you send the document via **mail or email** you must **include** the bottom section of this notice (**see dotted line**).

**Notices about
KI-HIPP
Payments/Claims**

Description

Direct Deposit Failure Notice tells the KI-HIPP policy holder when there is an issue or error with their bank account direct deposit.

Why did I receive this?

This notice explains that **you must enter the correct information for your bank account direct deposit**. This means that KI-HIPP premium payments will not be directly deposited into your bank account until the correct bank information is confirmed.

This notice lists the possible errors that may have occurred when you initially set up your direct deposit and the information you entered.

You must provide the correct bank information to receive KI-HIPP direct deposits.



You will receive **KI-HIPP payments** as a **physical check** instead of a direct deposit until the correct bank information is confirmed.

Direct Deposit Failure Notice

This letter is to inform you of an error with your bank account direct deposit. If there is a change in the bank account information, you will not get your Premium Payment deposited to your bank account until the correct information is confirmed. In the meantime, you will get a check for your Premium payment in the mail.

You entered the following information when setting up for your bank account direct deposit:

Date	<Bank Account details verification date>
Bank Name	<Verified Bank name>
Address	<Verified Bank Address>
Account Number	*****<Last 4 digits of Account number>

Below are some possible errors with your bank account direct deposit:

- The account has not been confirmed
- The account information is incorrect
- The account is closed (or frozen)
- The account number is incorrect
- The routing number is incorrect

Please see below for an example of where to locate the bank account and routing number:

If you have questions, please call 855-459-6328.

If you want or need legal help, you may get free legal help from your local legal aid office at <Legal Aid Number>.



* More information on page 40.

Description

Direct Deposit Failure Notice tells the KI-HIPP policy holder when there is an issue or error with their bank account direct deposit.

Please see below for an example of where to locate the bank account and routing number:

The image shows a check with the following fields: 'Check Number' (0012), 'Date', 'Pay To The Order Of', '\$', 'Dollars', 'Memo', 'AUTHORIZED SIGNATURE', and MICR line (⑆ 123456789 ⑆ 012345678912 ⑆ 0012). Arrows point from the MICR line to labels: 'Routing Number' (123456789), 'Account Number' (012345678912), and 'Check Number' (0012).

If you have questions, please call 855-459-6328.

If you want or need legal help, you may get free legal help from your local legal aid office at [<Legal Aid Number>](#).

What are my next steps?

If you received this notice for one of the errors listed below, **complete the following steps to correctly set up direct deposit KI-HIPP payments:**

Error	Your Next Steps
Incorrect Account Information	1. On a copy of a voided check, deposit ticket, or KI-HIPP-63 Direct Deposit Authorization Form , enter the correct information for the following:
Incorrect Account Number	1. Account Number
Incorrect Routing Number	2. Routing Number
	<i>*See example of check to locate correct information.</i>

For other direct deposit errors, please call one of the numbers below:

Call **855-459-6328** for questions about the direct deposit failure.
For legal help or advice, call your attorney or local legal aid office.

Description

Benefits Reduction Notice tells the KI-HIPP member that they received higher KI-HIPP payments than they are eligible to receive. Due to the higher KI-HIPP payments received, the member will receive reduced KI-HIPP payments to pay off the claim.

Why did I receive this?

This notice explains that you mistakenly received a higher claim in KI-HIPP payments than you should have gotten, which means **a claim must be paid**.

Your KI-HIPP payments will be reduced to pay off this claim.

Example: You are eligible to receive \$60 in KI-HIPP payments each month. Last month, you got a higher KI-HIPP payment of \$100 by mistake. You got \$40 **more** in KI-HIPP payments than you are eligible to receive, which means you owe a \$40 claim to the state. To pay off the \$40 that you owe, you will only get a \$20 KI-HIPP payment next month.



Your **KI-HIPP payments** will be **reduced** until the outstanding claim is paid off.



Benefits Reduction Notice

Your household received \$**<Claim amount>** more in KI-HIPP payments than you should have for the month(s) of **<Claim begin month>** through **<Claim end month>**. The reason for this is: **<Claim Reason>**.
The Commonwealth of Kentucky may collect this debt based on **<Rules reg>**.

Because you continue to receive KI-HIPP benefits, we will **lower** your **KI-HIPP payment amount** until the \$**<Claim amount>** has been repaid. This may mean you will not get payments for several months. **We will lower your KI-HIPP payment starting** **<Benefit Reduction Start Month>**.

Call 855-459-6328 for questions on your KI-HIPP claim if:

- You have questions about how we figured the amount you owe.
- You want a copy of month by month calculations that show why you owe this amount.
- You want the opportunity to inspect and/or copy records related to your claim.
- You have any other questions.

If you want legal help or advice, you may call your attorney or local legal aid office at: **<Legal Aid Office Number>**

What are my next steps?



You do not have to do anything because your KI-HIPP payments are **automatically** reduced until the claim is paid in full.



Call **855-459-6328** for questions about the reduced payments.
For legal help or advice, call your attorney or local legal aid office.

Description

Claim Adjustment Notice tells the enrolled KI-HIPP member that the KI-HIPP Team adjusted (i.e. increased or decreased) their KI-HIPP claim amount.

Why did I receive this?

This notice explains that the KI-HIPP claim amount you owe **increased or decreased** for **one** of the following reasons:

Reason	Description
A You sent a bad check (i.e. check was written on an account that did not have enough funds to cover the amount of the check)	You must replace the check with a money order or a cashier's check (<u>NOT</u> another personal check)
B You paid off the claim in full	You no longer owe a claim
C You owe a claim as an <i>active</i> KI-HIPP member (i.e. currently receiving KI-HIPP payments)	You will receive KI-HIPP payments that are <i>automatically</i> reduced to pay off the claim

<HIP-XXX> COMMONWEALTH OF KENTUCKY Date: <Date>
<(MM/YY)> Cabinet for Health and Family Services * Claim Number: <Claim No.> *
<Department for Medicaid Services>

KI HIPP
Kentucky Integrated Health Insurance Premium Payment

Claim Adjustment Notice

On <Claim Adjustment Date> your debt was <increased/decreased> by \$<Claim Adjustment Amount>.
This change was made because <Claim Adjustment Reason>.

*** A** Bad Checks Dynamic Text:

Your check was returned due to insufficient funds. You must replace the check with a money order or cashier's check immediately. Do not send cash or another personal check.

You owe \$<Pending Amount>.

What do you need to do?

- Please make your check or money order payable to the Kentucky State Treasurer. Do not send cash.
- Include claim number <Claim number> on your payment.
- Send payment to: 275 E. Main St., 8C-A, Frankfort, KY 40621

We will send you a receipt showing the amount you paid and what you still owe.

If you are unable to pay the entire amount at this time, please contact this office at 855-459-6328.

If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>.

<HIP-XXX> COMMONWEALTH OF KENTUCKY Date:
<(MM/YY)> Cabinet for Health and Family Services Claim Number: <Cl
<Department for Medicaid Services>

B Zero Balance Dynamic Text

As of this date, your KI-HIPP debt is paid in full. This applies to this KI-HIPP debt only. You may have other debts you still owe to this office. If so, you should continue to make regular payments for those debts.

C Balance Greater than zero Dynamic Text but actively receiving KI-HIPP benefits:

You now owe \$<Pending Amount>

Because you **are getting** KI-HIPP benefits, we will reduce your future **KI-HIPP payment until** the \$<Pending Amount > has been repaid. This may mean you will not get KI-HIPP payments for several months.

If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>

Tear here and return the bottom portion with your payment in the enclosed envelope.

NAME: <Client First MI Last Name> CLAIM NUMBER: <Claim Number>

Description

Claim Adjustment Notice tells the enrolled KI-HIPP member that the KI-HIPP Team adjusted (i.e. increased or decreased) their KI-HIPP claim amount.

<p><HIP-XXX> COMMONWEALTH OF KENTUCKY Date: <Date> <(MM/YY)> Cabinet for Health and Family Services * Claim Number: <Claim No.> * <Department for Medicaid Services></p> <p style="text-align: center;">KI HIPP <small>Kentucky Integrated Health Insurance Premium Payment</small></p> <p style="text-align: center;"><u>Claim Adjustment Notice</u></p> <p style="border: 2px solid green; padding: 5px;">On <Claim Adjustment Date> your debt was <increased/decreased> by \$<Claim Adjustment Amount>. This change was made because <Claim Adjustment Reason>.</p> <p>A Bad Checks Dynamic Text:</p> <p>Your check was returned due to insufficient funds. You must replace the check with a money order or cashier's check immediately. Do not send cash or another personal check.</p> <p>You owe \$<Pending Amount>.</p> <p>What do you need to do?</p> <ul style="list-style-type: none"> • Please make your check or money order payable to the Kentucky State Treasurer. Do not send cash. • Include claim number <Claim number> on your payment. • Send payment to: 275 E. Main St., 6C-A, Frankfort, KY 40621 <p>We will send you a receipt showing the amount you paid and what you still owe.</p> <p>If you are unable to pay the entire amount at this time, please contact this office at 855-459-6328.</p> <p>If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>.</p>	<p><HIP-XXX> COMMONWEALTH OF KENTUCKY Date <(MM/YY)> Cabinet for Health and Family Services Claim Number: <Claim No.> <Department for Medicaid Services></p> <p>B Zero Balance Dynamic Text:</p> <p>As of this date, your KI-HIPP debt is paid in full. This applies to this KI-HIPP debt only. You may have other debts you still owe to this office. If so, you should continue to make regular payments for those debts.</p> <p>C Balance Greater than zero Dynamic Text but actively receiving KI-HIPP benefits:</p> <p>You now owe \$<Pending Amount></p> <p>Because you are getting KI-HIPP benefits, we will reduce your future KI-HIPP payment until the \$<Pending Amount> has been repaid. This may mean you will not get KI-HIPP payments for several months.</p> <p style="background-color: yellow;">If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>.</p> <p>Tear here and return the bottom portion with your payment in the enclosed envelope.</p> <hr style="border-top: 1px dashed red;"/> <p>NAME: <Client First MI Last Name> CLAIM NUMBER: <Claim Number></p>
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What are my next steps?

Based on the reason that you received this notice, you must complete the following steps:

Reason	Your Next Steps
<p>A You sent a bad check (You must replace the check with a money order or a cashier's check*)</p> <p><i>*Do NOT send another personal check</i></p>	<ol style="list-style-type: none"> 1. Write the claim number on a check or money order (see asterisks in top right) 2. Mail the following documents to the KI-HIPP Team: <ul style="list-style-type: none"> • Cashier's Check OR Money Order (made payable to the Kentucky State Treasurer) • Bottom section of this notice (see dotted line)
<p>B You paid off the claim</p>	<p>You do not have to do anything because you no longer owe a claim (i.e. you already paid off the claim in full)</p>
<p>C You owe a claim as an active KI-HIPP member</p>	<p>You do not have to do anything because your KI-HIPP payments are <i>automatically</i> reduced to pay off the claim</p>



Call **855-459-6328** for questions about payment receipts.
For legal help or advice, call your attorney or local legal aid office.

Description

Claim Termination Notice tells the KI-HIPP member that their existing KI-HIPP claim has been closed. This means the claim no longer requires payment.

Why did I receive this?

This notice explains that your existing KI-HIPP claim no longer has an outstanding amount and does not require further payment.



You **do not owe any further payments** because the claim you previously owed has been **closed** and/or **paid off**.

Kentucky Integrated Health Insurance Premium Payment (KI-HIPP)

Claim Termination Notice

As of **<Claim Termination Date>**, we have closed your KI-HIPP debt of \$**<Claim Balance Amount>** for benefits received for the month(s) **<Claim begin month through <Claim end month>**. You can stop paying this debt.

This applies to this debt only. You may have other debts you still owe. If so, you should continue to make regular payments for those debts.

If you have questions, please call 855-459-6328.

What are my next steps?



You do not have to do anything because you no longer owe a claim.



Call **855-459-6328** for questions about claim termination.

Description

Notice of KI-HIPP Supplemental Payment informs the policy holder that they are receiving additional payments due to an increase in their health insurance premiums.

Why did I receive this?

This notice explains that the policy holder's group health insurance premium has increased based on your recent paystub for the current month. As a result, the KI-HIPP program issues supplemental payments to make-up for the difference in the health insurance premium payments that you missed out on during the current month.



Notice of KI-HIPP Supplemental Payment

You have reported that your group health insurance premium payment has increased. Based on that change, you will get the following KI-HIPP supplemental payment(s):

Primary Policy Holder Name	Policy ID	Month	Amount
< Primary Policy Holder Name >	<Policy ID >	<Month Year>	<Monthly Supplemental amount>
< Primary Policy Holder Name >	<Policy ID >	<Month Year>	<Monthly Supplemental amount>

If you have questions, call us at 855-459-6328.

What are my next steps?



You do not have to do anything. Your next KI-HIPP payments automatically reflect the supplemental amount!



If you have questions about your KI-HIPP payments, please reach out to the KI-HIPP team directly. You may email the KI-HIPP team at: KIHIPP.Program@ky.gov

Description

KI-HIPP Issuance Stopped Notice informs the policy holder that their payments are being stopped for a specified period.

Why did I receive this?

This notice explains that it was reported that the policy holder is not making health insurance premium payments for a specified period. As a result, their KI-HIPP payments have been temporarily stopped.

KI-HIPP Issuance Stopped

Why?

You have told us that you are not making health insurance premium payments for the period of **<DAY MONTH, YEAR>** until **<DAY MONTH, YEAR>**. Based on that change, you will not get the following KI-HIPP payment(s):

Primary Policy Holder Name	Policy ID	Expected Issuance Date	Issuance Amount
<Policy Holder Name>	<Policy ID>	<Day Month Year>	<\$Amount>
<Policy Holder Name>	<Policy ID>	<Day Month Year>	<\$Amount>

KI-HIPP Address: <KI-HIPP Return Address>

Email: <KI-HIPP Email>

If you have questions, call us at <KI-HIPP Call Center Number>.

What are my next steps?

If you have questions about your KI-HIPP payments, please reach out to the KI-HIPP team directly. You may email the KI-HIPP team at: KIHIPP.Program@ky.gov

**Notices for
Disenrolled
KI-HIPP Members**

Description

Demand Notice requests claim payment from the **disenrolled** KI-HIPP member within 30 days of the notice being mailed out.

Why did I receive this?

This notice explains that you must pay an outstanding claim for the higher KI-HIPP payment you mistakenly received. **You are responsible for paying** your claim because you were **disenrolled from KI-HIPP** (i.e. **not** currently receiving KI-HIPP payments).



You must **mail a check** or **money order** to pay off the outstanding claim.

*This notice is different from the Benefits Reduction Notice because you do not currently receive KI-HIPP payments that could be used to pay off an outstanding claim.

<HIP-XXX>
 <MM/YY>
 COMMONWEALTH OF KENTUCKY
 Cabinet for Health and Family Services
 <Department for Medicaid Services>

* Claim Number: <Claim No.> *

< Name >
 < Address >

Demand Notice

Your household received \$<Claim amount> more KI-HIPP benefits than you should have for the month(s) <Claim begin month> through <Claim end month>. The reason for this is: <Claim Reason>.

You owe \$<Pending Amount>.

The Commonwealth of Kentucky may collect this debt based on <Rules reg>.

Your payment is due within 30 days from the date of this letter. Please make payment by check or money order payable to the Kentucky State Treasurer. Do not send cash!

Send payment to: CHFS
 KI-HIPP Unit
 275 E. Main St., 6C-A
 Frankfort, KY 40621

If you are unable to pay the entire amount at this time, please contact us at 855-459-6328.

Please write claim number <Claim Number> on your check or money order. We will send you a receipt showing the amount you paid and what you still owe.

Please note that if you have a pending KI-HIPP payment, we may reduce this amount from your KI-HIPP payment.

If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>.

Tear here and return the bottom portion with your payment in the enclosed envelope.

NAME: <Client First MI Last Name> CLAIM NUMBER: <Claim Number>

What are my next steps?

- 1 You must write **claim number** on a check or money order (**see asterisks in top right**)
- 2 You must **mail the following documents** to the KI-HIPP Team within **30 days** from the date listed (**see dotted box in the top right corner**):
 - **Check** or **Money Order** for amount owed (made payable to **Kentucky State Treasurer**)
 - Bottom section of this notice (**see dotted line**)

If you **cannot** pay the **full amount**, please call **855-459-6328**.

Description

Payment Past Due Notice tells the **disenrolled** KI-HIPP member that they did not send a payment in full within 30 days of the **Demand Notice**.

Why did I receive this?

This notice explains that you did not fully pay off your outstanding claim within 30 days of the Demand Notice. The claim you owe is now delinquent.

You are responsible for paying your delinquent claim because you are **disenrolled** from KI-HIPP (i.e. not currently receiving KI-HIPP payments).



You must **mail a check** or **money order** to pay off the outstanding claim in full.

<HIP-XXX> <(MM/YY)>	COMMONWEALTH OF KENTUCKY Cabinet for Health and Family Services <Department for Medicaid Services>	Date: <Date> * Claim Number: <Claim No.> *
 Payment Past Due Notice		
Your payment of \$<Payment Amount> was due on <Claim Due Date>. We have not gotten your payment.. It is now past due.		
What do you need to do?		
<ul style="list-style-type: none">• Please make your check or money order payable to the Kentucky State Treasurer. Do not send cash.• Include claim number <Claim number> on your payment.• Send payment to: CHFS KI-HIPP 275 E. Main St., 6C-A Frankfort, KY 40621		
We will send you a receipt showing the amount you paid and what you still owe.		
If you have questions, please call 855-459-6328.		
If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>.		
Tear here and return the bottom portion with your payment in the enclosed envelope.		
NAME: <Client First MI Last Name> CLAIM NUMBER: <Claim Number>		

What are my next steps?

To pay off the outstanding claim in full, you must complete the following steps:

- 1 Write the **claim number** on a check or money order (**see asterisks in top right**)
- 2 **Mail the following documents** to the KI-HIPP Team:
 - **Check** or **Money Order** for amount owed (made payable to **Kentucky State Treasurer**)
 - Bottom section of this notice (**see dotted line**)



Call **855-459-6328** for questions about payment.

For legal help or advice, call your attorney or local legal aid office.

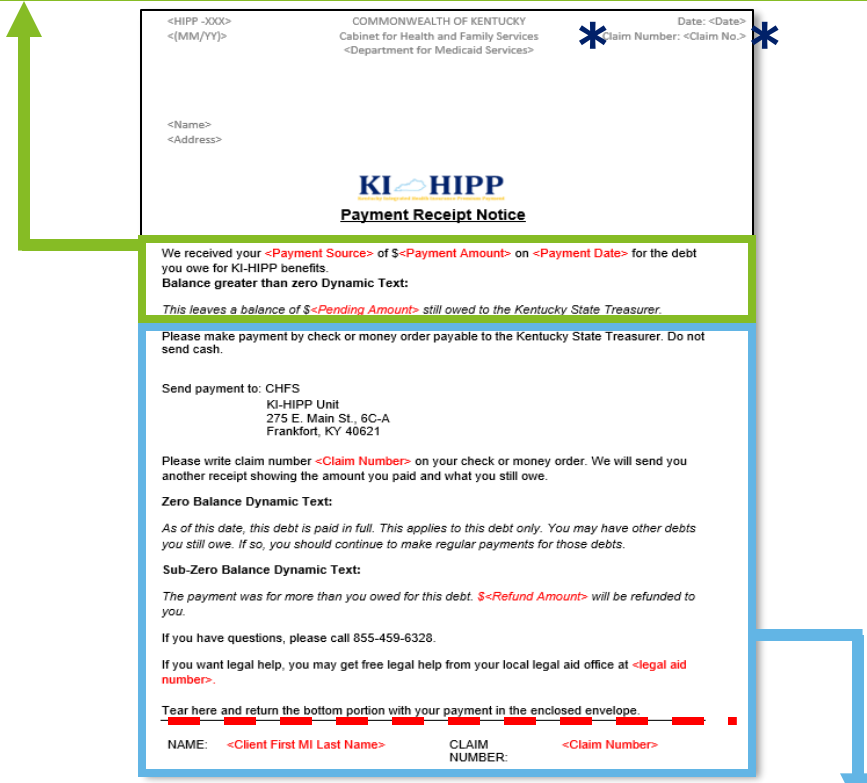
Description

Payment Receipt Notice tells the **disenrolled** KI-HIPP member that their check or money order used to pay an outstanding claim has been received.

Why did I receive this?

This notice explains that your check or money order used to pay a claim has been received. Depending on the amount paid, you received this notice for **one** of these reasons:

Reason	Description
★ You did not pay off the claim in full	You still owe a remaining amount of the claim
You paid off the claim in full	You no longer owe a claim
You paid more than you owed	You will receive a check refunding you for the overpaid amount



What are my next steps?

★ **If you did not pay off the claim in full**, you must complete the following steps to pay off the remaining amount of the claim:

- 1 Write the **claim number** on a check or money order (**see asterisks in top right**)
- 2 **Mail the following documents** to the KI-HIPP Team:
 - **Check or Money Order** for amount owed (made payable to **Kentucky State Treasurer**)
 - Bottom section of this notice (**see dotted line**)

Call **855-459-6328** for questions about payment receipts. For legal help or advice, call your attorney or local legal aid office.

Description

Claim Adjustment Notice tells the **disenrolled** KI-HIPP member that the KI-HIPP Team adjusted (i.e. increased or decreased) their KI-HIPP claim amount.

Why did I receive this?

This notice explains that the KI-HIPP claim amount you owe **increased or decreased**. **You are responsible for paying** your delinquent claim because you are **disenrolled** from KI-HIPP (i.e. not currently receiving KI-HIPP payments).

You are responsible for paying because you are **disenrolled** from KI-HIPP



You must **mail a check or money order** to pay off the outstanding claim in full.



<HIP-XXX> COMMONWEALTH OF KENTUCKY Date: <Date>
 <(MM/YY)> Cabinet for Health and Family Services * Claim Number: <Claim No.> *
 <Department for Medicaid Services>

Claim Adjustment Notice

On <Claim Adjustment Date> your debt was <increased/decreased> by \$<Claim Adjustment Amount>.
 This change was made because <Claim Adjustment Reason>.

* **Balance Greater than zero Dynamic Text but not actively receiving KI-HIPP benefits:**
 You now owe \$<Pending Amount>.

What do you need to do?

- Please make your check or money order payable to the **Kentucky State Treasurer**. Do not send cash.
- Include claim number <Claim number> on your payment.
- **Send payment to:** 275 E. Main St., 6C-A, Frankfort, KY 40621

We will send you a receipt showing the amount you paid and what you still owe.

If you are unable to pay the entire amount at this time, please contact this office at 855-459-6328

If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>.

Tear here and return the bottom portion with your payment in the enclosed envelope.

NAME: <Client First MI Last Name> CLAIM NUMBER: <Claim Number>
 NUMBER:

Description

Claim Adjustment Notice tells the **disenrolled** KI-HIPP member that the KI-HIPP Team adjusted (i.e. increased or decreased) their KI-HIPP claim amount.

<HIP-XXX>	COMMONWEALTH OF KENTUCKY	Date: <Date>
<(MM/YY)>	Cabinet for Health and Family Services	* Claim Number: <Claim No.> *
	<Department for Medicaid Services>	
Claim Adjustment Notice		
On <Claim Adjustment Date> your debt was <increased/decreased> by \$<Claim Adjustment Amount>.		
This change was made because <Claim Adjustment Reason>.		
Balance Greater than zero Dynamic Text but not actively receiving KI-HIPP benefits:		
You now owe \$<Pending Amount>.		
What do you need to do?		
<ul style="list-style-type: none">• Please make your check or money order payable to the Kentucky State Treasurer. Do not send cash.• Include claim number <Claim number> on your payment.• Send payment to: 275 E. Main St., 6C-A, Frankfort, KY 40621		
We will send you a receipt showing the amount you paid and what you still owe.		
If you are unable to pay the entire amount <u>at this time</u> , please contact this office at 855-459-6328		
If you want legal help, you may get free legal help from your local legal aid office at <legal aid number>.		
Tear here and return the bottom portion with your payment in the enclosed envelope.		
NAME: <Client First MI Last Name>	CLAIM NUMBER:	<Claim Number>

What are my next steps?

To pay off the outstanding claim in full, you must complete the following steps:

- 1** Write the **claim number** on a check or money order (**see asterisks in top right**)
- 2** **Mail the following documents** to the KI-HIPP Team:
 - **Check or Money Order** for amount owed (made payable to **Kentucky State Treasurer**)
 - Bottom section of this notice (**see dotted line**)



Call **855-459-6328** for questions about payment receipts.
For legal help or advice, call your attorney or local legal aid office.

Description

Good Cause Rejection Notice tells the **disenrolled** KI-HIPP member that their request for Good Cause has been rejected.

Why did I receive this?

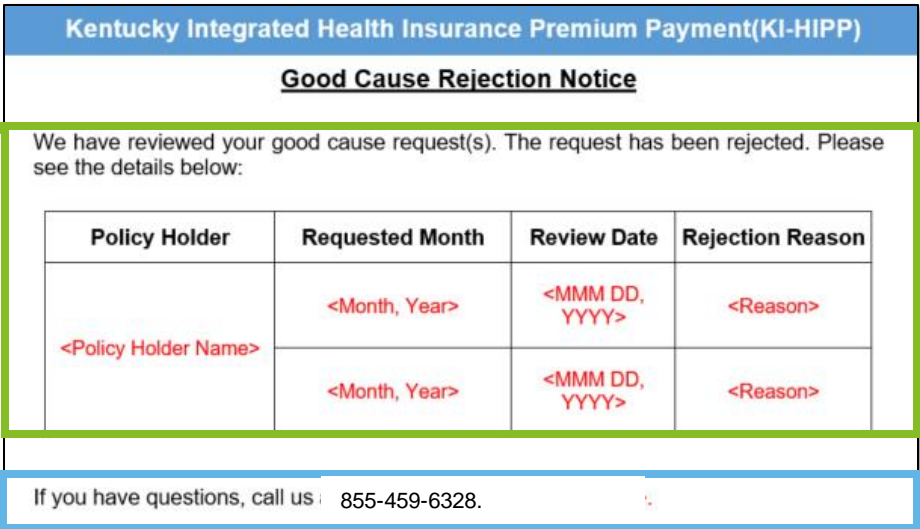
This notice explains that your **Good Cause request has been rejected**.

This means you will not receive a Good Cause payment.

As a **disenrolled** KI-HIPP member, you requested Good Cause to receive KI-HIPP payments for past months where you did not send your paystubs as proof of premium payment. On your Good Cause request, you explain that you have valid reason for not sending your paystubs (e.g. you were on a Medical leave of absence from work). The KI-HIPP Team approves or rejects your Good Cause requests.

Your Good Cause request was rejected for one of these reasons:

- You did not send any documents showing Good Cause
- You sent documents that did not have enough detail to show Good Cause
- Your Good Cause Reason was invalid
- You are currently enrolled in an MCO



What are my next steps?



You do not have to do anything because you are no longer enrolled in KI-HIPP.

Requesting Good Cause does **not** mean you are re-enrolled in KI-HIPP.

Call **855-459-6328** for more information on how to re-enroll in KI-HIPP and for any questions about Good Cause.

Appendix

How can KI-HIPP benefit me?

The benefits below are offered to enrolled KI-HIPP members. To get the most of your KI-HIPP benefits, please read the Best Practices at the bottom.

Benefit	Description
<p>May widen healthcare network by providing access to providers and healthcare services through the full Medicaid network</p>	<ul style="list-style-type: none"> Medicaid members will continue to have access to their current Medicaid benefits Additionally, you and your family may have access to providers and services through the full traditional Medicaid network
<p>May help make employer health insurance affordable by reimbursing the policy holder for the ongoing insurance premiums</p>	<ul style="list-style-type: none"> KI-HIPP helps members pay the cost of health insurance premiums, which is the amount the policy holder pays to the health insurance company for coverage Once enrolled in KI-HIPP, the policy holder will receive ongoing payments to help cover their share of the health insurance premium
<p>May allow an entire family to be on the same health insurance plan and access the same doctors</p>	<ul style="list-style-type: none"> If the family health insurance plan is eligible, KI-HIPP will pay the cost of covering the entire family on one health insurance plan

★ **Please Note:** The choice of provider impacts the cost of services. KI-HIPP does **NOT** cover out-of-pocket costs for the Medicaid member if the provider is a Non-Medicaid Provider (does not accept Medicaid).

Best Practices for Medicaid Members:

- 1 Medicaid members are encouraged to receive healthcare services and fill prescriptions from providers that **accept Medicaid**.
- 2 Medicaid members on the policy must provide **both** of the following documents when paying for services or a prescription:

Medicaid Card



Health Insurance Card



KI-HIPP will cover costs if:

The Member visits a Medicaid Provider

KI-HIPP will NOT cover costs if:

The Member Visits a Non-Medicaid Provider

Resources

The resources below include important phone numbers and website links you can visit for additional information or assistance:

Report a Change

- Go to **kynect benefits** at kynect.ky.gov **OR**
- Contact DCBS at **855-306-8959**

Provider Directory

- Search for **In-Network Providers** via the **Partner Portal Provider Directory**:
<https://prdweb.chfs.ky.gov/ProviderDirectory/PDSearch.aspx>

Additional Information

- Visit the KI-HIPP webpage for more information about KI-HIPP:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Documents may be submitted to the KI-HIPP Team using one of the following methods:



Upload:

kynect.ky.gov/benefits



Mail:

CHFS KI-HIPP Unit
275 E. Main St. 6C-A
Frankfort, KY 40621



Email:

kihipp.program@ky.gov



For any questions about the KI-HIPP program,
please call **855-459-6328**.