KI HIPP
Kentucky Integrated Health Insurance Premium Payment

Kentucky Integrated Health Insurance Premium Payment Program Application

KIHIPP-100

Medicaid can help eligible individuals and families pay for health insurance coverage offered by your job, COBRA, United Mine Workers, or a Retiree Health Plan. This Medicaid program is called Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program. Complete this form if you (the Primary Policy Holder) have access to or enrollment in health insurance coverage.

Step 1: Primary Policy Holder Information (This is the person who carries the insurance.)

1. First Name Middle Name Last Name			
2. Social Security Number	3. Date of Birth (MM/DD/YYYY) _____/_____/_____	4. Gender ☐ Male ☐ Female	5. Use Tobacco?* ☐ Yes ☐ No
6. Home Address			
7. City	8. State	9. Zip Code	
10. Mailing Address, if different			
11. City	12. State	13. Zip Code	
14. Phone Number	15. Phone Type ☐ Home ☐ Cell ☐ Work ☐ Other	16. Email	
17. How would you like to receive notices? ☐ Paper ☐ Electronic – email only ☐ Electronic – email & SMS			

*Tobacco use question is for informational purposes only and does not affect Medicaid coverage.

Step 2: Health Insurance Policy Information

18. Do you have access to this insurance plan or are you already enrolled? ☐ Access ☐ Enrolled		
19. What is the source of this health insurance plan? ☐ Employer-Sponsored Insurance ☐ COBRA ☐ United Mine Workers ☐ Retiree Health Plan		
20. Employer Name	21. Employer Phone Number	
22. Health Insurance Company Name	23. Health Insurance Company Phone Number	
24. Health Insurance Company Address		
25. City	26. State	27. Zip Code
28. Plan Name	29. Plan Start Date (MM/DD/YYYY) _____/_____/_____	
30. Group Number, if enrolled	31. Policy ID Number, if enrolled	
32. Tier of Coverage ☐ Employee ☐ Employee + spouse ☐ Employee + Dependents ☐ Family	33. Premium per Frequency $_____	34. Frequency ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

Step 3: Covered Individuals

Tell us about the individuals that are covered on your health insurance plan if you are enrolled, or the individuals that you hope to cover if you have access only.

Spouse

a. First Name | Middle Name | Last Name

b. Social Security Number | c. Date of Birth (MM/DD/YYYY) _____/_____/_____ | d. Gender ☐ Male ☐ Female | e. Use Tobacco?* ☐ Yes ☐ No

f. Is this individual on Medicaid? ☐ Yes ☐ No | g. Medicaid ID Number, if known

Dependent 1

a. First Name | Middle Name | Last Name

b. Social Security Number | c. Date of Birth (MM/DD/YYYY) _____/_____/_____ | d. Gender ☐ Male ☐ Female | e. Use Tobacco?* ☐ Yes ☐ No

f. Is this individual on Medicaid? ☐ Yes ☐ No | g. Medicaid ID Number, if known

h. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other _____

Dependent 2

a. First Name | Middle Name | Last Name

b. Social Security Number | c. Date of Birth (MM/DD/YYYY) _____/_____/_____ | d. Gender ☐ Male ☐ Female | e. Use Tobacco?* ☐ Yes ☐ No

f. Is this individual on Medicaid? ☐ Yes ☐ No | g. Medicaid ID Number, if known

h. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other _____

Dependent 3

a. First Name | Middle Name | Last Name

b. Social Security Number | c. Date of Birth (MM/DD/YYYY) _____/_____/_____ | d. Gender ☐ Male ☐ Female | e. Use Tobacco?* ☐ Yes ☐ No

f. Is this individual on Medicaid? ☐ Yes ☐ No | g. Medicaid ID Number, if known

h. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other _____

Dependent 4

a. First Name | Middle Name | Last Name

b. Social Security Number | c. Date of Birth (MM/DD/YYYY) _____/_____/_____ | d. Gender ☐ Male ☐ Female | e. Use Tobacco?* ☐ Yes ☐ No

f. Is this individual on Medicaid? ☐ Yes ☐ No | g. Medicaid ID Number, if known

h. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other _____

If you have more than 4 dependents, use Appendix A to provide more information about your household.

Step 4: Authorization

- I am signing this form under penalty of perjury, which means I have given true answers to all the questions on this form including appendix to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
    - I know that I must tell the Department for Medicaid Services (DMS) if anything changes from what I wrote on this form within 30 days of the change. I can visit kynect.ky.gov or call 855-459-6328 to report any changes.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file. I understand that my eligibility for Medicaid will not be impacted by my tobacco use status. If my plan is not eligible for KI-HIPP, I may get Medicaid.
- I understand that DMS will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or any other trusted sources. If the information does not match, I may be asked to send proof.

If I am eligible for Kentucky Integrated Health Insurance Premium Payment Program:

- I understand that if Kentucky Integrated Health Insurance Premium Payment Program pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid, as applicable, to reimburse it for the expense.
- I understand that my Health Coverage form may be reviewed to make sure that eligibility was determined correctly. If my form is reviewed, I must cooperate with the review.

Signature	**Date (MM/DD/YYYY)** _____/_____/_____

If you need help with your form or to complete faster online, go to kynect.ky.gov or call 855-459-6328. You may upload the documents required in step 5 on kynect.ky.gov, or send to:

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

KI-HIPP Email: kihipp.program@ky.gov

Step 5: Verification

You must submit the required documents:

- Summary of Benefits and Coverage (SBC), including all deductibles, coinsurance amounts, copays, and covered services;
- Premium rate sheet;
- Health insurance card, front and back, if enrolled; and
- Recent paystub, showing insurance deduction, if enrolled.

Appendix A: Additional Covered Individuals

Tell us about the individuals that are covered on your health insurance plan if you are enrolled, or the individuals that you hope to cover if you have access only. Only complete Appendix A if you ran out of room in Step 3. You can use as many of this page as you need to list your dependents.

Dependent #___			
i. First Name	Middle Name	Last Name	
j. Social Security Number	k. Date of Birth (MM/DD/YYYY) _____/_____/__________	l. Gender ☐ Male ☐ Female	m. Use Tobacco?* ☐ Yes ☐ No
n. Is this individual on Medicaid? ☐ Yes ☐ No	o. Medicaid ID Number, if known		
p. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other ______________________________			

Dependent #___			
i. First Name	Middle Name	Last Name	
j. Social Security Number	k. Date of Birth (MM/DD/YYYY) _____/_____/__________	l. Gender ☐ Male ☐ Female	m. Use Tobacco?* ☐ Yes ☐ No
n. Is this individual on Medicaid? ☐ Yes ☐ No	o. Medicaid ID Number, if known		
p. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other ______________________________			

Dependent #___			
i. First Name	Middle Name	Last Name	
j. Social Security Number	k. Date of Birth (MM/DD/YYYY) _____/_____/__________	l. Gender ☐ Male ☐ Female	m. Use Tobacco?* ☐ Yes ☐ No
n. Is this individual on Medicaid? ☐ Yes ☐ No	o. Medicaid ID Number, if known		
p. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other ______________________________			

Dependent #___			
i. First Name	Middle Name	Last Name	
j. Social Security Number	k. Date of Birth (MM/DD/YYYY) _____/_____/__________	l. Gender ☐ Male ☐ Female	m. Use Tobacco?* ☐ Yes ☐ No
n. Is this individual on Medicaid? ☐ Yes ☐ No	o. Medicaid ID Number, if known		
p. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other ______________________________			

Dependent #___			
q. First Name	Middle Name	Last Name	
r. Social Security Number	s. Date of Birth (MM/DD/YYYY) _____/_____/__________	t. Gender ☐ Male ☐ Female	u. Use Tobacco?* ☐ Yes ☐ No
v. Is this individual on Medicaid? ☐ Yes ☐ No	w. Medicaid ID Number, if known		
x. Relationship to Policy Holder ☐ Child ☐ Step-child ☐ Other ______________________________			