



ARHIPP INITIAL APPLICATION

Arkansas Health Insurance Premium Payment (ARHIPP) is a program that helps working families and adults pay for health insurance coverage.

To qualify for ARHIPP, your application must show:

1. There is at least one Medicaid member in your household
2. A household member is either currently enrolled or has access to health insurance that will cover at least one person that is Medicaid eligible
3. The state will save money by paying for the cost of your Medicaid dependent's healthcare premium (This is determined after you submit your application.)

At this time, individuals currently enrolled in ARKids or Medicare are not eligible for ARHIPP program consideration.

To apply for the ARHIPP program, fill out the attached application and either fax, email, or mail it back to us, along with a copy of the front and back of your **insurance card**, **employer rate sheet** (if available), **summary of benefits**, and a recent **paystub or other verification** to show your premium payment.. For faster processing, we ask that you please follow all instructions while completing your application.

Fax: 1-855-777-1001

Email: myarhippcustomerservice@gainwelltechnologies.com

Mail: ARHIPP, 1818 N. Taylor St. #360, Little Rock, AR 72207

If you have any questions, please contact the ARHIPP program at our toll-free phone number 1-855-692-7447.

Sincerely,

The ARHIPP Team

Toll free phone: 1-855-MyARHIPP (855.692.7447) | Monday to Friday 8:00AM to 5:00PM

Fax: 1-855-777-1001 | Email: myarhippcustomerservice@gainwelltechnologies.com

Website: www.myarhipp.com

Arkansas HIPP is a program of the Arkansas Department of Human Services.



Arkansas Health Insurance Premium Payment Initial Application: PART I

PART I of this application is to be filled out by the APPLICANT. PART II of this application should be filled out by the policyholder’s EMPLOYER, such as a Human Resource representative or Benefits Coordinator.

- 1. Do you or anyone in your family receive Medicaid Benefits? YES NO
- 2. Do you or anyone in your family have health insurance? YES NO

2.a. IF YES, which type: EMPLOYER COBRA OTHER

2.a.i. What is the premium for this policy (if known)? \$_____ These premiums are paid/ deducted:

<input type="checkbox"/> Weekly	<input type="checkbox"/> Every other week	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other
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2.a.ii Type of Coverage: Individual Individual and child Individual and Spouse Family

2.b. **IF NO,** can you or anyone in your family get other insurance through employment? YES NO

Tell us as much as you can about the health insurance plan that you have access to as well as information about the employer providing the plan in questions 3 to 4. If you answered no, and do not have any way of obtaining employer-sponsored insurance, please skip to PART II.

3. Please complete this section with the policyholder’s information. If you do not have access to health insurance, please skip to PART II.

Name of Policy Holder: _____

Physical Address: _____

City/ State/ Zip: _____

Mailing Address: _____

City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____ Email (Required): _____

Yes, it is okay to send important information about ARHIPP and my ARHIPP payments to my email address provided above. (Check box if this statement is accurate.)

SSN: _____ DOB: _____

Insurance Company: _____

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Policy Number (Mandatory): _____ Group Number: _____

RX Group: _____ RX BIN: _____ RX PCN: _____

Effective Date of Policy: _____ End Date: _____ Other: _____

4. List everyone in your household covered by your policy, including Medicaid recipients. (Use extra paper if necessary.)

Name	Social Security Number	Birth Date	Medicaid ID Number	Relationship to Policyholder	Gender	Condition
		/ /				
		/ /				
		/ /				
		/ /				

5. DIRECT DEPOSIT (Check box to sign up for Direct Deposit): If accepted into the ARHIPP program, I would like to participate in Direct Deposit. By doing so, ARHIPP will deposit my payments into my checking account, and I will not receive a paper check. If I am not accepted into the program, ARHIPP will properly discard my banking information.

Bank Name: _____ Routing #: _____ Account #: _____
(Please provide a copy of your voided check with this application.)

Type of Account (Please check one): Checking Savings

Checking account: Please do not forget to attach a copy of your voided check. Your voided check has your bank's routing number and bank account number; both are needed to send your payment by direct deposit.

Savings account: Your bank account number and ABA routing numbers are needed. You may contact your bank if you do not know these numbers.

6. How did you first hear about HIPP? _____

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Arkansas Health Insurance Premium Payment Initial Application: PART II

PART II should be filled out by the policyholder’s EMPLOYER, such as a Human Resource representative or Benefits Coordinator. This form is to be completed on behalf of the ARHIPP applicant that has selected "Employer" as their type of healthcare policy plan.

1. Has employment terminated for the employee listed above? YES, Date: _____ NO

2. Employer Information:

Employer Name: _____ Federal Tax ID (Mandatory): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

How many full time individuals does your company currently employ? _____

3. Employer-sponsored health insurance information:

Do you offer insurance to your employees? YES NO

If YES, please complete the rate table below.

*Please complete the table below using family plan rates for each health insurance plan offered OR attach your company rate sheet. Also, please provide a **Summary of Benefits** for the health insurance plan accessible to the applicant.*

	Carrier Name	Plan	Persons Covered	Monthly Employer Contribution	Monthly Employee Contribution	Group #
Individual						
Individual + Spouse						
Individual + Child						
Family						

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Arkansas Health Insurance Premium Payment Application PART II (continued)

3. Employer-sponsored health insurance information (continued):

If you offer insurance to your employees, does this individual have access to purchasing a family plan?

YES NO

When does your company’s open enrollment period start and end (If applicable)?

Start: __/__/__ End: __/__/__

4. Applicant’s History:

Has the individual listed above withdrawn from a family health plan within the last six months? YES

NO

If YES, which plan? _____ Plan Termination Date: _____

5. Your Information:

Name (Print): _____ Signature: _____

Your Title: _____ Date Signed: _____

Phone: _____ Ext: _____

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You can either fax, email, or mail a copy of this form back to the HIPP program.

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Arkansas HIPP (ARHIPP) Initial Application Checklist

To ensure that we have the most recent information about you and confirm that you continue to remain eligible for the Arkansas HIPP program, please return the following Renewal Forms and documentation listed below within 10 days of the date of this renewal packet. Please follow letter instructions to forward items for consideration.

Have you included?

_____ **PART I** of the application completed by the ARHIPP member/applicant.

_____ **PART II** of the application should be completed by the policyholder's EMPLOYER (Human Resources representative or Benefits Coordinator). Please be sure to include the open enrollment dates.

_____ Front and back of policyholder's insurance card

_____ Employer rate sheet

_____ Summary of benefits

_____ A recent paystub of other verification to show your premium payment

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