pennsylvania
DEPARTMENT OF HUMAN SERVICES

HIPP Application

System Code: **Region #:** **C/R#:** **Telephone #:** **Date:**

Tell us about the person in your household who may be able to get health insurance at work or has lost a job in the last 30 days.

NAME	SSN

ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE	CELL

If no one in the household is working or lost a job in the last 30 days note it in the employment status box, sign and return this form.	EMPLOYMENT STATUS

Tell us about the employer.

Are you currently employed? ☐ Yes ☐ No If no, when was employment terminated?

EMPLOYER NAME	PHONE

ADDRESS	CITY	STATE	ZIP CODE

Tell us about the health insurance or COBRA benefits available.

Is the employee currently enrolled in health insurance? ☐ Yes ☐ No If no, when will the employee be eligible to enroll?

Is this COBRA coverage? ☐ Yes ☐ No If yes, when was the COBRA begin date?

List household members who are currently on employer insurance or may be added.

Name:	Relationship to Employee:	Is this person receiving treatment for a serious illness, mental health, behavioral health, or orthodontics?	Is this person pregnant?
1.		ILLNESS	DUE DATE
2.		ILLNESS	DUE DATE
3.		ILLNESS	DUE DATE
4.		ILLNESS	DUE DATE
5.		ILLNESS	DUE DATE

List anyone in the household who may be able to get health insurance through a non-custodial parent.

Name:	Name of Non-custodial Parent	Employer Name	Non-custodial Parent's Phone
1.			
2.			
3.			

I hereby authorize and request the disclosure to the PA Department of Human Services any information that would be needed to determine eligibility for the Health Insurance Premium Payment, HIPP, Program, and appoint the department my limited attorney-in-fact with the power to elect group health benefit coverage on my behalf, to enroll me in such coverage and to pay premiums or contributions on my behalf. This power of attorney shall remain in effect until revoked in writing by me. I understand this information will be kept confidential and will be used only for the purpose of determining eligibility for the HIPP Program. In compliance with federal HIPAA privacy regulations, I understand and agree that the HIPP Program may use and disclose protected health information (including but not limited to name, address, diagnosis and treatment) for treatment, payment or health care operations. I understand that I must consent to this use and disclosure in order to enroll in or receive services through the HIPP Program

EMPLOYEE SIGNATURE:	DATE: