PARTIAL PAYMENT AGREEMENT
OA-HIPP PROGRAM

The following information is required for applicants whose health insurance premiums exceed the OA-HIPP Program payment limits.

I. Applicant Information

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name

Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code

Telephone Number (Home)	Telephone Number (Alternate)

II. Current Insurance Plan Information (must attach a copy of your member ID card and billing statement)

Payee Name	Payee Contact Name	Payee Telephone Number	
Payee Address (Number, Street, or P.O. Box)	City	State	Zip Code
Payee's Federal Tax ID Number	Member ID/Policy Number	Monthly Premium Amount $	

Monthly Program Threshold $	Monthly Difference $	Quarterly Amount Due (Monthly Difference x 3) $

Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS. The information may be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

☐ I understand that I am an applicant with a monthly health insurance premium that exceeds the Office of AIDS Health Insurance Premium Payment (OA-HIPP) program limits and that I am financially responsible to pay the difference between the monthly premium amount and the program threshold.

☐ I understand that I must submit a money order to OA with this form, made payable to the Payee Name listed above, for the amount equivalent of three months of the difference owed between the monthly premium amount and the program threshold. I will submit additional money orders for that amount for each future quarter, due on the first of the following month(s), _____ , _____ . In the event that the premium amount increases, I will notify OA of the additional amount I owe and I will pay the adjusted amount.

☐ I understand that I will be terminated from the OA-HIPP Program and I will no longer be eligible to receive OA-HIPP services if I fail to pay the portion of the premium that I am responsible for.

☐ I certify that the information provided on this form is true and correct to the best of my knowledge.

_____ _____

Applicant's Signature Date