AIDS Drug Assistance Program (ADAP)
Insurance Assistance Programs Partial Payment Agreement

The following information is required for applicants whose health insurance premiums exceed the Program's payment limits.

I. Applicant Information

First Name______________________________ Middle Initial_______ Last Name____________________________

Date of Birth____________________________ Client ID (optional)_______________________________________

Residential Address (Number, Street, Apartment Number)____

City ________________________ State________ Zip Code_________________ County _______________________

Mailing Address (if different than residential address)____

City ________________________ State________ Zip Code_________________ County _______________________

Phone Number (Residential)_________________________Phone Number (Alternate)_________________________

II. Current Insurance Plan Information

(must attach a copy of your billing statement)

Health Plan Name__________________________________ Health Plan effective date[1]_________________________

Monthly Health Plan Premium Amount__________ Monthly Program Threshold ____**$2996.00**________________

Client Monthly Portion Due[2] _________________________

III. Certification

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 (OA). 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 the CDPH, OA- HIPP Program, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (844) 421-7050. I understand that I am an applicant with a monthly health insurance premium that exceeds the Health Insurance Premium Payment Assistance Program limit and that I am financially responsible to pay the difference between the monthly premium amount and the program threshold.

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[1] The health plan's effective date is the date when your health coverage begins for you.

[2] Client's monthly portion will be the difference between their total monthly insurance premium amount and the monthly program threshold of $2,996.00

IV. Submitting Payment

I understand that prior to sending payment, I must submit a copy of the Partial Payment Agreement to CDPH via fax at (844) 421-8008 or submit the Partial Payment Agreement to my ADAP Enrollment Worker who will upload to the ADAP Enrollment System for processing.

I understand that enrollees must pay their monthly insurance premiums until it has been confirmed that their application has been approved and payment has been submitted to the health plan.

I understand that I can make a payment using one of the following methods:

- Mail a cashier's check, money order, or personal check (client will be responsible for any fees associated with insufficient funds when submitting a personal check), **made payable to Pool Administrators, Inc./CDPH**, to Pool Administrators, Inc. (PAI) at the following address: **628 Hebron Avenue, Suite 502, Glastonbury, CT 06033.**

- Electronically submit payment using PayPal:
  1. Create an account at **www.paypal.com.**
  2. Select **Money**
  3. Select **Send or request Money**
  4. Select **Pay for Goods or Services**
  5. Enter CDPH_CA_PAY@pooladmin.com and Select **Next**
  6. Select your method of payment and enter the partial payment amount
  7. Verify the shipping address: **628 Hebron Ave., Suite 502, Glastonbury, CT 06033**
  8. Select **Send Payment Now**

  Please contact PAI at (877) 495-0990 if you need additional assistance with submitting an electronic payment using PayPal.

Payments will be due by the 1st of each month. I understand that my portion is the difference between the monthly premium amount and the program threshold **I understand that PAI will not make an insurance premium payment on my behalf until my portion of the premium is processed and updated in my account.**

If my monthly insurance premium amount increases, I must notify ADAP and submit a new billing statement and Partial Payment Agreement form that reflects the new premium amount.

I understand that I will be terminated from the Health Insurance Premium Payment Assistance Program and will no longer be eligible to receive premium payment assistance if I fail to pay the portion of the premium that I am responsible for.

By signing this form, I hereby certify that the above information is factual, accurate, and complete. I agree to immediately notify ADAP of any changes in my insurance premium. I understand that failure to provide accurate information or deliberately omitting information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.

Applicant's Signature ____ Date________________________