HEALTH INSURANCE PREMIUM PROGRAM (HIPP)

GUIDELINES, RULES AND PROCEDURES

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ABOUT THE AMERICAN KIDNEY FUND

As the nation's leading nonprofit working on behalf of the 30 million Americans with kidney disease, the American Kidney Fund (AKF) is dedicated to ensuring that every kidney patient has access to health care, and that every person at risk for kidney disease is empowered to prevent it.

AKF fulfills its mission by providing a complete spectrum of programs and services: prevention outreach, top-rated health educational resources, and direct financial assistance enabling 1 in 5 U.S. dialysis patients to access lifesaving medical care, including dialysis and transplantation. AKF invests in clinical research to improve outcomes for kidney patients and fights tirelessly on Capitol Hill for legislation and policies supporting the issues that are important to kidney patients. To address the enormous public health threat of kidney disease, AKF provides public and professional health education materials, courses and webinars; Know Your Kidneys™, including Kidney Action Day® events, a community education and free health screening program; a Kidney Health Educator program; and a toll-free health information HelpLine 866-300-2900). AKF's grassroots fundraising community, KIDNEY NATION, unites Americans who are raising funds to support the organization’s mission.

Our independent Board of Trustees is comprised of volunteers with a broad range of talents and professional backgrounds, who are dedicated to AKF’s mission. These board members include: philanthropists, business leaders, attorneys, certified public accountants, renal professionals and kidney patients. Our full Board listing can be found at http://www.kidneyfund.org/about-us/#about_governance.

AKF maintains a Health Insurance Premium Program (HIPP) that is overseen by an independent subcommittee of the Board. In accordance with an Advisory Opinion issued by the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS- OIG), we ensure that no member of the HIPP oversight subcommittee is an employee, officer, shareholder, or owner of any dialysis provider.

More than 62,000 individuals, corporations and foundations support our mission through charitable contributions. AKF spends more than 97 cents of every donated dollar on patients and programs. AKF holds the highest ratings from the nation's charity watchdog groups, such as Charity Navigator, which includes AKF on its “top 10” list of nonprofits with the longest track records of outstanding stewardship of the donated dollar. In addition, AKF holds an A+ rating from CharityWatch, adheres to the National Health Council Standards of Excellence, and is a member of the Better Business Bureau Wise Giving Alliance. For more information, visit KidneyFund.org.
SECTION 1: OVERVIEW OF HIPP

The Health Insurance Premium Program (HIPP) is one of AKF’s needs-based financial assistance programs for dialysis patients. We established HIPP in 1997 after the program received a favorable review from the Office of Inspector General for the Department of Health and Human Services (HHS-OIG) in Advisory Opinion (AO) 97-1. For more information regarding AO 97-1, please see the “Additional Information” section of this document.

HIPP provides premium assistance to end stage renal disease (ESRD) patients who are eligible for health insurance coverage but who lack the financial resources to pay the premiums. HIPP is available to every ESRD dialysis patient in the United States who has documented financial need. Each year, this program helps tens of thousands of kidney patients from all 50 states, the District of Columbia, and US territories maintain access to all of the life-sustaining healthcare benefits covered by their insurance plans.

HIPP grants are available to cover premiums for health insurance coverage under Medicare Part B, Medicare supplemental plans (Medigap), Medicare Advantage plans (Part C), Medicaid/state insurance programs (where states require residents to pay premiums), Employer Group Health Plans (EGHP), Consolidated Omnibus Budget Reconciliation Act (COBRA) plans, and commercial insurance plans—including plans within the Marketplace Exchanges.

HIPP enables patients to maintain health insurance coverage and thereby have access to the comprehensive medical care that is covered under their health plan. This may include; dialysis treatment, hospitalization, doctor’s visits, prescription medicines, kidney transplant workups and transplants. Having access to this care enhances treatment outcomes and reduces hospitalizations.

When we evaluate a dialysis patient’s eligibility for HIPP assistance, the only factor we consider is whether the patient is in financial need and meets our program eligibility criteria. We do not take into consideration the identity of the patient’s dialysis provider. We do not base the grant approval on the patient’s choice of insurance carrier or plan. We do not consider the patient’s health status.

To determine eligibility for participation in HIPP, AKF requires a grant application and attestation form signed by the ESRD patient who is applying for assistance. The application requires the patient to provide detailed personal financial information. Applications must be co-signed by a renal professional. This co-signing requirement helps us to confirm that the applicant is an ESRD patient and meets all of the AKF eligibility criteria detailed on page 8. After we receive the patient’s application, it is reviewed by an AKF Patient Services staff member, who may request any additional information that may be required to process the application. The AKF staff member then determines whether the patient qualifies for AKF grant assistance.
In the majority of cases, patients who have been approved for HIPP will then request assistance on an ongoing basis by submitting a recurring grant request to AKF. Continuing eligibility is reviewed at least once every two years.

When an existing HIPP patient receives a transplant, we provide health insurance premium assistance to the patient through the end of the insurance coverage plan year. For example, a patient whose health plan year is on a calendar basis and who receives a transplant in May would be eligible to receive HIPP assistance through the end of December. If the transplant occurs in the final quarter of a plan/policy year and AKF has already begun paying premiums for the next plan/policy year, then AKF will continue grant assistance for the full new plan/policy year.

Persons eligible to receive post-transplant assistance must already have been receiving HIPP assistance for at least three consecutive months prior to the time of their transplant. This provision is designed to ensure that HIPP assistance is provided to those who are most in financial need. It is the patient’s responsibility to inform AKF when their treatment status has changed and to ensure that AKF has accurate contact information so that HIPP grants may be processed in a timely fashion. Patients must work with their dialysis social worker and transplant center to make sure that they understand their post-transplant coverage and related health insurance premium grants.

When a patient receives grant assistance from AKF, it does not matter where they dialyze or what type of dialysis they choose. We do not help patients choose a dialysis clinic or other health care providers. If patients change facilities, they must alert their new renal professional that they were previously receiving assistance through HIPP and renal professional will need to submit a Facility Change Request Form so that we can update the patient’s contact information in our system.

We review grant requests on a “first-come, first-served” basis. Grants are subject to the availability of funds in our HIPP funding pool. We are proud to provide, on average, a turnaround of 10 to 14 business days for HIPP applications that are fully and correctly completed. The HIPP program is totally funded through voluntary contributions. While AKF works vigorously to raise program funding, we cannot guarantee the availability of program resources. In the event that we lack sufficient resources to fund all requests, we reserve the right to prioritize requests based upon such factors as patient need, financial status, or other factors. AKF may also choose to only assist existing patients in the program by suspending the program to new patients.

Although we provide grants to cover premiums, it remains the patient’s responsibility to fulfill all the terms of his or her health insurance contract.
How We Help:

☑ We help patients maintain their health insurance coverage for a plan that they have selected.
☑ We help patients based solely on financial need and not on their overall health status.
☑ We help patients on a first-come, first-served basis, without regard to patient’s choice of dialysis provider (including, for example, whether the dialysis provider makes charitable contributions to AKF) or health insurance coverage.
☑ We continue assistance to qualified ESRD patients for a full plan year after they qualify for the program, even if they change insurance, change dialysis provider, or receive a transplant.
☑ Through HIPP, we help patients access all of the healthcare services offered under their health insurance coverage, including comprehensive coverage, transplant workups, and transplants.

We Do Not:

☒ Help a patient select new insurance coverage or choose between their available insurance options.
☒ Advise patients on choice of dialysis clinic, transplant center, health care treatments, and providers.
☒ Make awards of financial assistance under HIPP on any basis other than the patient’s financial need and program eligibility.

Enhancing Patient Freedom of Choice in Health Care Providers

If a patient enrolled in HIPP decides to change dialysis providers during the plan year, he or she will continue to receive HIPP assistance from AKF.

Patients are free to choose any healthcare provider. A patient’s decision to change his or her healthcare provider has absolutely no bearing on the assistance we provide. This concept is specifically highlighted in AO 97-1, which notes that “the insurance coverage purchased by AKF will follow a patient regardless of which provider the patient selects, thereby enhancing patient freedom of choice in health care providers.”

* To ensure patients receive quality care and that they have a full range of healthcare options, participating HIPP providers must be Medicare-certified.
Program Eligibility

HIPP is available to ESRD patients on dialysis who have limited means (based on monthly income & reasonable monthly expenses) of paying their primary and/or secondary health insurance premiums and who would lose coverage in the absence of assistance from HIPP.

Patient Eligibility

☑ Applicants must reside in the U.S. or its territories
☑ Applicants must receive regular dialysis treatment for ESRD in the U.S. or its territories. Patients receiving dialysis care for acute kidney failure are not eligible for assistance.
☑ Applicants must meet the eligibility qualifications of the insurance coverage for which premium assistance is being requested.
☑ Applicants must demonstrate that they cannot afford health coverage. Currently, the eligibility criteria are that monthly household income may not exceed reasonable monthly expenses by more than $600. If an applicant has no income at the time of application, the applicant will be required to provide an explanation. Total liquid assets, such as savings accounts and investment accounts may not exceed $7,000 (IRAs and other retirement accounts are excluded and are not counted toward this amount). AKF reserves the right to request additional information and documentation, as it relates to reported income, expenditures and all reported application information and can change the financial eligibility thresholds.
☑ Savings up to $1,500 formally set aside for burial expenses in a bank account, other financial instrument or prepaid burial arrangement will be exempted as an asset.
☑ Continuing eligibility for HIPP assistance is reviewed at least once every two years. In order to continue receiving HIPP assistance, the patient must meet the HIPP qualifying criteria that are in effect at the time of the review.
☑ No payments from HIPP will be made in connection with the premiums of a deceased patient, even if the invoice for the premium predates the death of the patient.

Insurance Eligibility

☑ Patients should carefully review all forms of health insurance coverage (Medicare Part B, Medicare Advantage (Part C), Medicaid/state insurance plans, Medigap, COBRA, EGHP, commercial insurance (including Marketplace plans)), and available assistance for paying health insurance premiums (Medicaid, state and local assistance, charitable organizations) and select the combination that best serves their specific financial needs and medical condition. HIPP does not assist with tertiary coverage of any kind, nor does HIPP assist with gap insurance.
HIPP payments cannot be requested to cover Medicaid spend downs or Share of Cost. If a premium is associated with a patient’s Medicaid policy, this premium may be covered by HIPP.

HIPP payments may not be used to cover prescription drug plans, including Medicare Part D plans. Prescription coverage assistance may be available when it is included as part of the patient’s major medical insurance policy.

**Patient Responsibility**

- The patient is responsible for applying for HIPP assistance. Only the patient can apply for a grant and sign an attestation form. However, the renal professional may enter the application into the Grants Management System (GMS) on behalf of the patient. The information contained within the application must be verified by a renal professional, and submitted applications must include confirmation from that qualified renal professional that the patient has ESRD and is receiving dialysis treatment.

- The receipt of financial assistance from HIPP does not alter the fact that health insurance coverage represents a contractual relationship solely between the patient and his or her health insurance plan, not between AKF and the health insurance plan. The patient assumes all responsibilities applicable to enrollees of the plan. The patient is responsible for selection of the health insurance that best meets their financial and medical needs.

- **The patient, as the health insurance plan holder, is solely responsible for paying his or her health insurance premiums** in a timely manner. While AKF seeks to pay premiums on or before due dates, AKF is not liable if health insurance coverage is terminated for any reason.

- AKF seeks to pay all grants directly to patients’ insurance plans whenever possible. In some situations, however, AKF must send grants directly to patients. In those instance, a check or debit card will be provided to the patient. In such instances, patients are responsible for using the funds to pay their health insurance premium bill in a timely manner. Failure to use the funds for the intended purpose will result in ineligibility for continued HIPP assistance.

- All Attestation Forms must be signed by the patient who is requesting HIPP assistance. If the patient is unable to sign the Attestation Form, a legally authorized representative of the patient (e.g., a person who has a power-of-attorney) may sign on behalf of the patient. In such case, a copy of the authorization (e.g., a valid power-of-attorney designation) must be submitted with the Attestation Form. The signed Attestation Form cannot be older than 60 days of the application submission date.

- Patients receiving Marketplace plans that include a tax subsidy are responsible for reporting to their insurer any changes that may affect these subsidies and/or the
overall premium amount due. AKF is not responsible for any penalties that may be imposed by the IRS, the patient’s insurer, or any other entity.

☑ Any premium refund in connection with any health insurance plan paid by AKF from the HIPP funding pool is the property of AKF and must be promptly returned to AKF. These refunds are deposited in the HIPP funding pool to support the program. If a HIPP enrollee dies, the insurance plan should be notified and a request made by the patient’s representative to refund any unused portion of the premium payment to AKF. Some plans refund checks directly to the patient’s estate. In this case, a patient’s family or estate representative must return those refunds to AKF so they can be placed in the HIPP funding pool.

☑ Assistance from HIPP is not available for “smoker’s surcharges” or other fees. Patients are responsible for ensuring that these fees are paid in a timely manner, as failure to do so may result in the cancellation of the patient’s insurance policy. Union dues cannot be requested unless they are a part of a “bundled” insurance premium that cannot be itemized.

☑ Dental and vision insurance will not be eligible for HIPP assistance unless those portions of the plans are inseparable from the patient’s health insurance plan. In other words, if these insurances are dependent on one another to maintain the patient’s health insurance, then HIPP assistance can be used to pay for these premiums.

☑ Premiums that have been paid by the patient or another source (including family/friends) prior to requesting assistance from HIPP will not be reimbursed.
SECTION 2: APPLICATION PROCESS

Application Submission

A completed HIPP application must be submitted through AKF’s Grants Management System (GMS) for consideration. Patients who are unable to submit a grant through GMS, should contact AKF directly for assistance. AKF does not represent that a properly completed application will be approved or, if approved, that insurance premium assistance from HIPP will be granted. To the contrary, the decision to provide assistance in response to any given application or request is at all times subject to the sole and absolute discretion of AKF. The award of a HIPP grant does not create a contract between AKF and the patient. See Appendix II.

All new applicants to HIPP shall be provided a copy of AKF’s HIPP Guidelines, the HIPP Patient Handbook, Patient Bill of Rights, and the HIPP Worksheet. When the patient signs their Attestation Form, the patient is confirming that he or she has read and understands the HIPP Guidelines and these other documents. This affirmation is intended to ensure that all prospective recipients of assistance from HIPP understand the benefits, responsibilities and limitations of participation in HIPP. Most importantly, patients need to be informed that HIPP assistance is limited to those with ESRD and that there are potential limits in the available HIPP funding pool. Copies of each document are available through AKF’s Grants Management System (GMS) (gms.kidneyfund.org) and AKF’s website (KidneyFund.org), or by calling AKF at 1.800-795-3226.

- Patients may start the application process on their own by completing a paper application worksheet. A patient may work through their dialysis social worker or other renal professional for online submission. If a patient does not want to or cannot work through their dialysis social worker, they should contact AKF by calling 1-800-795-3226 or email patientservice@kidneyfund.org. Patients may then register for a GMS account and track the status of their grant requests online via GMS.

- If a patient is working through their dialysis social worker, AKF will ONLY accept applications submitted ONLINE via the Grants Management System (GMS). If a patient is applying by themselves, AKF will work with the patient during the application and grant submission process.

- Online grant requests may be submitted as recurring requests. “One-time” requests may be submitted in situations where a rate increase occurs.
Application Review & Processing

- Please allow AKF at least 2 weeks to process and mail premium payments. Most grant payment requests, if correctly submitted, are processed within 10-14 business days (subject to funding availability). You may track progress through GMS.

- Urgent requests will be considered, based on the following rule:
  - Must have a termination date that will occur within 10 calendar days of the GMS grant request date.

- AKF reserves the right to verify all information and request additional written documentation.

- AKF reserves the right to request additional backup documentation to validate application information.

- AKF reserves the right to require new annual applications for all enrollees to ensure system accuracy and applicant eligibility.

- As long as the premium amount and payee remain the same, the patient enrolled in HIPP will not need to provide another premium bill to AKF until the beginning of the next insurance coverage plan year. In most cases, an insurance coverage plan year is governed by the insurance policy effective date and may not be a calendar year. Exchange plans must be updated at the end of each calendar year due to frequent changes in premiums and policy numbers.

Recurring payments will automatically be issued by AKF through the end of the HIPP enrollment year (subject at all times to the continued availability of funds and other restrictions noted above). **Note:** HIPP Liaisons are required to release all subsequent payments before AKF issues a grant check or debit card. This helps to mitigate the possibility of making unnecessary grant payments.

- A new online request is required (along with a current bill) if the patient has any change in insurance coverage or premium amount. This will update the automated payment information. Please notify AKF immediately if the patient passes away so that his or her record can be updated. If a patient receives a kidney transplant, the renal professional should notify AKF and also inform the patient to correspond with his or her transplant center about continuing his or her HIPP coverage through the end of the individual's insurance coverage year.

- In order to update the patient’s health insurance plan and premium amounts and to ensure proper contact information, a Facility Change Form is required when the patient permanently changes residence or dialysis center or transplant facility.
Acceptable Billing Documentation & Associated Requirements

HIPP payment requests must be accompanied by an insurance bill or coupon when applying initially or if the request is modified thereafter. Please follow the following guidelines for bill submission:

- Only bills/coupons from the current year will be accepted for the initial request. Subsequent bills may not be older than three (3) months from the grant payment request submission date.

- All bills/invoices must reference the insured’s name, policy number and coverage period. This information must match the online payment request.

- Whenever possible, AKF prefers that submitted bills include the exact coverage period and amount requested within the grant request. However, when patients cannot obtain these bills due to time constraints, the patient may use another bill issued within the past 90 days and manually write in coverage dates and/or premium amounts that correspond to the grant request. In these cases, patients should not “white out” the original information on the bill. Patients may simply draw one line through the original bill information and add the new information. AKF reserves the right to request additional written documentation.

- Insurance bills showing a “zero balance” or a credit balance will be accepted as long as the patient verifies with his or her insurance carrier that current coverage is up-to-date and that a premium payment is due. The policy coverage paid through date should also be included. Bills of this type will only be accepted for one-time grant requests.

- When requesting the reinstatement of a policy, a letter signed by an authorized agent or broker of the insurer may be submitted as a last resort in lieu of a bill. The letter must be on the letterhead stationery of the insurer. In all cases, the letter must reference the insured’s name, policy amount and coverage period. An actual current bill must be provided for the next payment request period. Agent/broker letters will only be accepted for one-time grant requests.

- A signed and dated copy of the new insurance application must be submitted when requesting assistance with a new policy for which a premium invoice has not yet been issued. The request should be submitted as a one-time grant payment request.

- If a premium is being deducted from the patient’s (or family member’s) paycheck, annuity, Social Security check or retirement check, it is permissible to request that the check be made payable to the patient (instead of to the insurer).

However, in the case of employer group health plans, the following procedures must be followed: The patient must request his or her employer to bill the patient directly. If the employer is not willing to do so, the employer must provide this in writing. A copy of this written statement must be provided to AKF.
This written communication from the employer should accompany the most current pay stubs for the current period requested, and indicate the individual medical portion of that patient’s insurance that is being deducted from the patient’s check.

- A rate sheet may be included to confirm the amount, but will not be considered a bill. This information is needed when initially requesting assistance through HIPP. If a rate sheet is not available, you may submit a letter from the employer’s HR department indicating the individual premium amount on company letterhead.

- If a patient has a new or existing insurance plan which requires that the premium be paid by bank draft or withdrawn from a check, patients may only request premium reimbursement from AKF for the current calendar month and subsequent months. Requests for previous months will be denied. Likewise, requests for “skipped” months due to failure to properly submit a grant for payment by AKF or enter a new grant within GMS may also be denied.

- In the event of a “bundled” family policy, AKF will only pay the individual rate for the patient. A rate sheet or letter from the employer, if applicable, must accompany the request to verify the bundled policy and rates.

- Should an individual rate not be available, AKF will pay the patient’s portion of the premium only (example: 50% for a family of two).

- If the premium rate is the same for individual and family coverage, AKF will pay the full premium amount.

- If the patient is the employee’s spouse, AKF will only pay the spouse’s premium amount.

- When a patient is on a Leave of Absence (LOA) or being covered by the Family Medical Leave Act (FMLA), a letter is required from the insured’s employer, on their letterhead, explaining the date that the patient begins their LOA or FMLA. Alternately, you may submit the approved HR form(s) with the patient’s signature indicated on the document. This should be entered as a one-time request in GMS, due to the uncertainty of the length of the patient’s FMLA or LOA.
SECTION 3: GRANT PAYMENTS

Grant Premium Payment Processing

To ensure efficiency and prompt payment of premiums, it is very important that AKF pays all grants directly to patients’ insurance companies whenever possible. However, some insurance companies do not accept third-party payments. In such cases, to ensure a patient receives their grant, AKF will mail checks or debit cards to the patient’s dialysis facility in care of his or her social worker. A list of insurance companies that do not accept third party payments directly from AKF is available for download via the GMS Important Messages window.

If the insurance company does accept third party payments, in those instances where the patient has previously had the premium deducted from his or her bank account, AKF requires that the patient change to direct billing prior to requesting assistance from HIPP so that the payment can be made directly to the insurance company.

*Once approved for HIPP, patients may choose to enter a one-time or recurring grant request. A recurring grant request will generate payments each billing period for an amount identical to the initial request.*

Program Applications

Patients whose initial program applications are approved will remain eligible to receive assistance for a full year, subject to available funds in the HIPP pool and the other criteria set forth above. AKF reserves the right to require new annual applications for all enrollees to ensure system accuracy and applicant eligibility.

Grant Requests

Once a patient’s program application is approved, the patient must submit a grant payment request in order to have grant payments made to the insurer, or to the patient when the health insurance carrier will not accept third party payments. The patient may choose to enter a one-time request or a recurring request in GMS. Should the patient choose to enter a recurring grant request, the patient’s HIPP Liaison must submit a grant payment request each quarter in order for the patient to continue receiving assistance.

If a patient has applied individually to AKF, they will be assigned an AKF contact. This contact will guide the patient through the application process.
Checking the Status of a Request

Patients and renal professionals may register to use AKF’s GMS to check the “real-time” status of program applications and grant requests. In addition, patients may check their grant request status by contacting Patient Services by phone at 1-800-795-3226, or by emailing patientservice@kidneyfund.org. Patient grant histories are also available.

Please allow at least two (2) weeks after submitting a premium grant request before checking on its payment status. To avoid the possibility of duplicate payment, patients should not resubmit a payment request without first checking online or speaking to a social worker (or other renal professional) at their dialysis facility. As a patient, if you do not have an assigned social worker, please speak to the administrator at your facility before resubmitting a payment request or contact Patient Services at 800-638-8299.

Premium payments will be issued based upon the billing schedule (monthly, bi-monthly, quarterly, semi-annually and annual) of the patient’s plan. AKF prefers to issue payments on a quarterly basis, ideally on the basis of the calendar quarters (i.e., Jan- Mar; Apr- June, etc.) Do not, however, attempt to force a payment request to conform to a calendar quarter if it is not normally billed in this manner. Some insurance plans bill on a bi-monthly basis. In this case, please request either a 2- or 4-month grant payment. As a reminder, once the initial grant payment of a recurring request is issued, patients must work with their renal professional (or their assigned AKF contact) to ensure that subsequent grant installments are released for payment within GMS.

AKF issues three types of grant payments:

- Checks payable to the insurance company, COBRA administrator or employer.
- Checks payable to the patient, sent to the patient’s dialysis facility, in care of their renal professional.
- Debit cards, sent to the patient’s dialysis facility, in care of their renal professional.

Changes In Patient Status

AKF must be notified of any patient status change (death, insurance termination, financial status and eligibility, etc.). In the case of a patient death, the patient’s renal professional may note within GMS that the patient is deceased.

Refunds

If a patient or renal professional is in receipt of a HIPP grant refund, the refund should be returned promptly to AKF. These funds are added back to the HIPP pool for future grant applicants.
Requesting A Check Reissue Or Copy

- To avoid incurring bank fees, AKF generally will not reissue checks or debit cards unless at least 45 days have elapsed from the date of initial issuance. When a patient or renal professional requests that a check or debit card be voided, AKF requires a written reason to be included.

- GMS provides information on patient grants, such as the check number, mailing address, status of a check sent to the insurance company, whether it has been cashed, and the date it was cleared. This information may also be obtained by contacting your AKF representative via email at patientservice@kidneyfund.org, or by calling Patient Services at 1-800-795-3226.

- In the event a check has not been cashed, please contact an AKF representative for further assistance. Please do not reenter a new/duplicate payment request to request a reissue, unless it is requested by an AKF representative.

- AKF does not automatically reissue uncashed checks. Reissues must be specifically requested. Be sure to return the uncashed check to AKF or dialysis company HIPP Liaison. Uncashed checks are automatically voided after 180 days.

- If it is found that the health insurance plan has not properly credited the account and the check has been cashed, AKF can provide a copy of the canceled check. Please allow at least 10 business days from the date of issuance of the check before requesting a copy. Once 10 business days have elapsed, check copies may be requested by calling Patient Services at 800-638-8299, or by contacting your AKF representative via email at patientservice@kidneyfund.org.

Debit Card Payments

In some cases, AKF issues grants in the form of debit cards. Debit cards are provided to patients to pay their insurance premiums and may not be used for any other purpose.

With each grant payment, patients will receive an actual plastic debit card, a letter of explanation, and a step-by-step infographic in English and Spanish. In order to use their debit card, patients must first activate the card using the included instructions. Questions regarding a debit card–related grant (including lost or cards not received) should be directed to AKF at DebitCards@kidneyfund.org or by calling 1-855-541-0950.

Requesting a Replacement Debit Card

- AKF does not automatically issue replacements for unused debit cards. Debit cards are automatically voided 180 days after they have been issued.

- If a patient does not receive a debit card that has been issued by AKF, or if the patient loses the card, the patient or their renal professional may contact AKF via phone (1-855-541-0950) or email (DebitCards@kidneyfund.org) to ask that the missing card
be voided. A new grant request may then be entered in GMS so that a new debit card may be issued and mailed to the patient’s facility.

- AKF does not have access to the debit card information (card number, etc.) and cannot provide it to the patient if the card is lost or stolen. As noted above, a new grant request will need to be entered to receive a replacement debit card.

It is not permissible for the patient or their renal professional to request a new card directly from our debit card vendor Comdata. Debit card issuance must be requested only through AKF.
SECTION 4: AKF’S ONLINE GRANTS MANAGEMENT SYSTEM (GMS)

What is GMS?

GMS is an online portal for applying for and managing AKF patient grants.

Who may register to use GMS?

GMS may be used by both patients and renal professionals.

For patients:

Registering to use GMS will make it easier for you to apply for HIPP assistance and to track the status of your grant requests. You may use your personal email address to register.

For renal professionals:

In order to use the GMS portal, renal professionals must have a valid individual corporate e-mail account. Corporate e-mail accounts are e-mail accounts that are restricted only to users (e.g., employees) authorized by your company and usually end in some form of your company name. Additionally, you may not use a shared general corporate email account; the email account must be specifically assigned to you. Personal e-mail accounts associated with publicly available Internet access (such as, but not limited to, Gmail, Yahoo, AOL, etc.) may not be used in connection with GMS. These rules are designed to help protect the confidentiality and security of patient information.

Through GMS, renal professionals can:

- Login to submit an attestation to a grant request or assist patients with applications.
- Obtain application and grant request status updates and patient grant histories.
- Upload required HIPP application or grant request back-up documents.
- Receive automated e-mails when a grant application is incomplete or requires attention.
APPENDIX 1 - ADVISORY OPINION

Consistent with AO 97-1, AKF established HIPP for the purpose of helping low-income end-stage renal disease (ESRD) patients maintain their existing health insurance coverage or obtain insurance for which they qualify. AO 97-1 describes the broad funding and operational model under which the program operates to this day, and establishes core protective tenets and guidelines to ensure the integrity and objectivity of the program. The 97-1 guidelines have been built into HIPP’s operation, and they help ensure the program continues to operate in a fair and ethical manner.

Consistent with AO 97-1, AKF relies on voluntary charitable contributions from dialysis providers and others. These contributions are made to AKF without any restrictions or conditions on AKF’s use of the donations, and AKF has the sole and absolute discretion to use the contributions as we deem appropriate.

A core protective tenet of HIPP under AO 97-1 is the firewall that separates our grants to ESRD patients from charitable contributions we receive from dialysis providers. We provide grants to patients with ESRD without consideration of whether a patient’s provider has contributed to AKF or, if the provider has contributed, the amount of such contribution. In fact, AKF staff who approve and process grant applications have no insight into which providers contribute to the HIPP pool. This “black box” system, the broad outlines of which are explained in AO 97-1, ensures that we are awarding grants to patients based solely on financial need and other objective eligibility criteria (described below). This system further ensures that as a 501(c)(3) charity, we maintain a donation firewall, with AKF having absolute control in deciding how to spend our donated funds.
The award of a HIPP grant does not create a contract between AKF and the patient or between AKF and the insurance plan. HIPP assistance is not guaranteed. There is no "right" to a grant or financial assistance, either initially or for any given period. AKF reserves the right to modify or withdraw at any time any commitment as to any grant or financial assistance. Without limiting the foregoing, a finding of eligibility does not guarantee ongoing financial assistance which, among other variables, depends on available funds in the HIPP pool. AKF reserves the right, exercisable in its sole and absolute discretion, to revise eligibility criteria, from time to time, and make such changes effective as of any date selected by AKF. AKF neither warrants nor represents that applications will be reviewed within any certain period of time. If an application is approved, AKF neither warrants nor represents that a HIPP grant or payment will be made within any certain period of time. AKF is not responsible for errors or delays, irrespective of the cause, either in the review of properly completed applications or issuance of checks, debit cards, or other forms of payments. In no event shall AKF be liable for damages alleged to have been caused by denials of applications; errors or delays in the review of applications; errors or delays in the issuance of checks, debit cards, or other forms of payments; delays in the U.S. postal system or commercial delivery services; or denial of coverage by health insurance companies. All applications to HIPP are irrevocably deemed submitted with the full acceptance of the foregoing by the patient.
CONTACT INFORMATION

If you have specific questions relating to HIPP, please contact AKF’s Patient Services department by calling 1-800-795-3226 or by emailing patientservice@kidneyfund.org. If you are new to HIPP and unsure of where to start, AKF’s Patient Services department will schedule an orientation to review the program, as well as provide an introduction to GMS.

For more information or to learn about GMS, visit AKF’s website at KidneyFund.org.

For assistance with GMS, please contact GMS Support by calling 1-800-795-3226 or by emailing GMSSupport@kidneyfund.org.

For questions regarding a debit card–related grant (including lost cards or cards not received), please contact AKF by calling 1-800-795-3226 or by emailing DebitCards@kidneyfund.org.

We hope these guidelines are helpful. If you have any additional questions, please do not hesitate to contact us. For our contact information, please see the information provided above.