Health Insurance Premium Program (HIPP) Grant Authorization & Consent Form

***This document must be completed if applying for HIPP Grant Assistance.**
Patient Confirmation- patient or authorized patient legal representative must initial.

- I understand that I am requesting AKF assistance with my health insurance policy premiums.
  Initial________

- I have reviewed and understand the out-of-pocket expenses (co-pays, deductibles, etc.) I may have as a result of choosing my coverage.
  Initial________

- I have reviewed and understand the impact, if there is any, of the coverage I have chosen on my ability to be placed on, or remain on, the kidney transplant list.
  Initial________

- I have received and read the AKF HIPP Guidelines or Patient Handbook.
  Initial________

- I acknowledge that the receipt of premium assistance from AKF does not affect my health insurance policy, which is a contractual relationship between myself and the insurance carrier (and not AKF). I understand that I am solely responsible for paying my insurance premiums in a timely manner.
  Initial________

- I agree that any premium refund in connection with any premium assistance provided by AKF is the property of AKF must be returned.
  Initial ________

- I have reviewed any government health programs (Medicare, Medicaid, TRICARE) that may be available to me.
  Initial ________

- I attest that all information on the grant request form submitted to AKF is factual to the best of my knowledge.
  Initial ________

- I attest that I have reviewed the health insurance options available to me and have had the opportunity to discuss them with my renal professional to the extent I have wanted to do so.
  Initial ________

- I understand that the choice of health coverage belongs solely to me.
  Initial ________

Patient's Signature * Date

Patient's Parent/ Legal Guardian/ Power of Attorney Signature * Date

*Signature date must be within 60 days from the date of the initial grant request to AKF. Proof of Power of Attorney/Legal Guardian is required. If the Patient is under 18, Parent/Legal Guardian signature is required. **You must submit the American Kidney Fund (AKF) Grant Authorization & Consent Form in addition to this document.**