Acknowledgement of Policies and Responsibilities
Health Insurance Premium Payment (HIPP) Program - Family Plan

This Acknowledgement of Policies and Responsibilities is to be signed by all members of a family health insurance plan who are separately enrolled in the AIDS Drug Assistance Program (ADAP) and are receiving or applying for HIPP program benefits which include the payment of health insurance premiums and outpatient medical out-of-pocket costs.

- I understand that in order to remain eligible to receive health insurance premium and/or outpatient medical out-of-pocket cost benefits, I must maintain my ADAP eligibility, which includes re-enrolling and recertifying timely.
- I understand that if my family health insurance plan is cancelled for any reason, my HIPP program benefits will cease.
- I understand that if my or my family member's ADAP eligibility lapses, my HIPP program benefit(s) may cease.
- I understand that this agreement is not valid unless my family member(s) who are on my health insurance plan and are separately enrolled in ADAP also sign this form.

By signing below I agree that I have read the information above. My signature also certifies my understanding of and agreement with the responsibilities outlined above.

Member #1

Client ID:_____ Date of Birth:_____

Client Name (Print):_____

Client Signature:_____

Member #2

Client ID:_____ Date of Birth:_____

Client Name (Print):_____

Client Signature:_____

Member #3

Client ID:_____ Date of Birth:_____

Client Name (Print):_____

Client Signature:_____