Statement of Client Rights & Responsibilities

I understand that as a participant in the **AIDS Insurance Continuation Program (AICP)**, I have both rights and responsibilities as listed below, and failure to comply with any one of the responsibilities can result in my termination from the program:

I have the right to freedom of choice - I have the right to choose to receive AICP case management and/or fiscal agent services from any organization within the State of Florida that has been duly authorized and trained by the AICP to perform such duties.

I have the right to submit grievances directly to the AICP Director for instances of denied enrollment, ineffective AICP case management, and/or ineffective fiscal payment services, etc.

I acknowledge that if I qualify for participation, the AICP may not be able to pay my premiums continuously if funding for the AICP is severely limited, or discontinued.

I acknowledge that it is my responsibility to keep my insurance active prior to the approval of my AICP application and that my enrollment in the AICP is dependant upon my possession of an active and valid health insurance policy, and that the payment of any health insurance premium back payments is my responsibility unless otherwise authorized.

I agree to continue paying my health insurance premiums until such time as my AICP case manager notifies me by phone, mail or in person that the AICP has accepted my application for official program enrollment, and indicates the date upon which AICP will begin paying my premiums.

I agree that if I am placed on the AICP delay-in-service waiting list, pending official program enrollment, the payment of all health insurance premiums will continue to be my sole responsibility, until such time that I am informed by my case manager that official program enrollment has occurred.

I will provide an insurance premium notice to my designated AICP case manager each month in order that my premium may be paid on time. I understand that if I do not provide this notice, even one time, the program will not pay my insurance premium, and my insurance company may cancel my policy.

I will make contact with my designated AICP case manager a minimum of once every 60 days, of which one contact every six-months must be in person. If I do not make this 60-day contact, even if my premium has already been paid for that period, my designated AICP case manager will assume that I am no longer in the program, will seek a refund for premiums already paid, and will not pay any future premiums.

I will immediately notify the community-based organization of changes of income, address, phone number, insurance policy information, premium increases or decreases.

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I will sign all forms and paperwork required by the program.

I will complete an annual AICP client survey once a year. The results of this survey will be tabulated, in aggregate form to protect my confidentiality, and will be included in an analysis of the effectiveness of the program.

I understand my rights and responsibilities listed above as conditions of participation in the insurance program. I will comply with all of these requirements.

I also acknowledge the following:

Acceptance into the AICP is not automatic upon application. The application is a process; involving those steps described in the information packet I have been given.

The Health Council of South Florida, Inc. reviews all documents forwarded to them by my case manager and either approves or denies my AICP application.

Acceptance into the AICP is based on my having met all enrollment criteria, and on the Program's ability to accept new clients at the time of enrollment.

Client Signature:	Case Manager Signature:
Print Name:	Print Name:
Date:	Date: