



Notice of Eligibility

Required Form

Date

Clients Name

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Client's Address

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It has been determined that you comply with the required eligibility requirements to receive allowable services from the Department of Health, Division of Disease Control, Bureau of HIV/AIDS, Patient Care Programs. Allowable services are based on availability, accessibility, funding and program qualifications for the AIDS Drug Assistance Program (ADAP), the AIDS Insurance Continuation Program (AICP), and the state Housing Opportunities for Persons with AIDS (HOPWA) specialty programs.

Your eligibility status for receiving allowable services from the HIV/AIDS Patient Care Programs is valid for 6 months from the date of this correspondence. You must have a new determination for eligibility no later than the expiration date provided below in order to continue services. You must advise the originating eligibility staff when there are changes which affect your eligibility status.

Your signature below acknowledges your understanding of the following:

- I have received a copy and verbal explanation of this notice.
- I understand the requirements for receiving HIV/AIDS services.
- I verify that I have complied with all of the Rights and Responsibilities in the Application as verified by my signature on the application.

Client's signature: _____

Date: _____

Eligibility staff signature: _____

Date: _____

Re-determination Date Due No Later Than

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Eligibility Staff Name

Phone

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Address

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Household Size

FPL

Income

Other Programs (list all that apply)

Keep this notice of eligibility in a safe place. Bring this notice along with photo identification when meeting with an ADAP, AICP, HOPWA, or case management representative about services.