

RE-DETERMINATION: NOTICE OF ELIGIBILITY

Date: _____

Name: _____

Address: _____

It has been re-determined by _____ 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, 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, _____, unless otherwise stated _____.

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 Part 6 of the Application as verified by my signature on the application.
- I verify (to my knowledge) that i do not have any private insurance, Medicaid, Veterans benefits or other source of payment for medications.

CLIENT'S SIGNATURE: _____ DATE: _____

ELIGIBILITY STAFF: _____ DATE: _____

NAME AND ADDRESS OF ELIGIBILITY OFFICE: _____
_____ OFFICE PHONE NUMBER: _____

YOUR REDETERMINATION DATE IS: _____

FPL: _____

HOUSEHOLD INCOME: _____

HOUSEHOLD CASH ASSETS: _____

HOUSEHOLD SIZE: _____

% MEDIAN HH INCOME: _____

VALID ONLY IF PRINTED ON ELIGIBILITY AGENCY LETTERHEAD

Keep this re-determination of eligibility in a safe place. Bring it with you and a photo ID when meeting with an ADAP, AICP, HOPWA , or case management representative about services.