

REQUEST FOR ELIGIBILITY EXCEPTION

Date of Request: _____ Individual ID # _____

Submitted by Eligibility Staff: _____ Date: _____

Originating Agency: _____

Originating Agency Phone # _____

A Request for Exception to one of the eligibility requirements requires the completion of this form in its entirety. Supervisory approval is required for all exception requests (and additional Bureau approval is required for income and cash assets between 300-350%). Please Note: The eligibility rule establishes the criteria for an exception as noted on this form.

(1) CHECK THE ELIGIBILITY REQUIREMENT IN QUESTION:

- Documentation of HIV
- Living in Florida
- Medicaid/Other Program Participation/Insurance (Payer of Last Resort)
- Household Income
- Cash Assets
- Willingness to Cooperate

(2) CHECK THE REASON(S) FOR THE EXCEPTION REQUEST:

- To prevent the loss of health insurance benefits, or
- To prevent hospitalization, or
- To ensure continued access to medications and treatment.

BOTH EXCEPTION CRITERIA MUST APPLY:

- An emergency situation, and
- A short-term circumstance (less than 180 days).

Justify the exception to the eligibility requirement based on the criteria above: _____

(Use additional Paper if necessary)

REVIEWS

Supervisory Review

Reviewer Name: _____ Date of Review: _____

Approved Not Approved

Explain: _____

Additional Local Review

Reviewer Name: _____ Date of Review: _____

Approved Not Approved

Explain: _____

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(OVER FOR BUREAU REVIEW OF FINANCIAL REQUIREMENTS (INCOME 300-350%))

MANDATORY SAFEGUARDS TO AVOID UNINTENTIONAL ERRORS

All Requests for Exception due to household income calculated between 300%-350% and cash assets which exceed \$12,000 must be reviewed by the Bureau of HIV/AIDS prior to issuing the Notice of Ineligibility. The following are the procedures (Chapter 10).

- (1) The completed Request for Exception must reflect approval from the supervisory and local reviews.
- (2) The originating eligibility office will assemble a copy of the following documents:
 - The completed application
 - The completed request for exception
 - The applicant's financial survey (if used)
 - The completed eligibility staff assessment worksheet
 - All the required financial documentation
 - The documents are mailed Certified Mail or Overnight Delivery with adherence to confidentiality procedures to the following address:

Department of Health, Division of Disease Control, Bureau of HIV/AIDS, ATTN: Eligibility Review, Patient Care Program Administrator, 2585 Merchants Row Boulevard, 3rd Floor, Room 345/350, Tallahassee, Florida 32399-1715.
- (3) A three-day turnaround (via phone and hard-copy) can be expected from the date of Bureau of HIV/AIDS receipt, unless more information is requested. The Bureau will document the results on the form and communicate directly with designated eligibility personnel.
- (4) ADAP staff only are required to complete the Request for Exception and contact the Bureau ADAP program staff directly by phone for existing ADAP clients presenting for a re-determination who are between 300%-350%.

BUREAU OF HIV/AIDS REVIEW

Date of Bureau Receipt: _____

Date of Bureau Review: _____

Request for Exception: Concurred _____ Not Concurred _____

Explain: _____

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