Notice of Eligibility

Attachment J
Required Form

Date	**Clients Name**

Client's Address

It has been determined that you comply with the required eligibility requirements to receive allowable services from the Department of Health, Bureau of Communicable Diseases, HIV/AIDS and Hepatitis, Patient Care Programs. Allowable services are based on availability, accessibility, funding and program qualifications for the AIDS Drug Assistance Program (ADAP), the ADAP Premium Plus (insurance), 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	

Eligibility Staff Name	Phone

Address

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, ADAP Premium Plus, HOPWA, or case management representative about services.

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