



# Notice of Ineligibility

**Attachment K  
Required Form**

**Date**

**Client's Name**

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**Client's Address**

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It has been determined by that you are ineligible to receive allowable services from the Department of Health, Bureau of Communicable Diseases, HIV/AIDS and Hepatitis, Patient Care Programs for the following reason(s):

You are not HIV positive	<input type="checkbox"/>
Your gross income is above 400% of the federal poverty line	<input type="checkbox"/>
Your are not living in Florida	<input type="checkbox"/>
You are unwilling to sign all forms and provide the appropriate eligibility information.	<input type="checkbox"/>
You are not willing to utilize your private or other third party insurance	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>

Please contact this agency with the appropriate documentation for a re-determination, if you have any changes in the above eligibility factors.

Your signature below acknowledges your understanding of the following:

- I have received a copy and verbal explanation of this Notice of Ineligibility.
- I have received referrals by eligibility staff for possible participation in other programs.
- I have been given a copy of the Notice of Rights, which is attached to this Notice.

(Chapter 64D-4, F.A.C.)

Client's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Eligibility staff signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Eligibility Staff Name**

**Phone**

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**Address**

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Household Size	
FPL	
Income	
Other Programs (list all that apply)	
Other Programs (list all that apply)	

**Keep this notice of ineligibility in the applicant's file.**