Request for Exception

Attachment P
Required Form

To be completed by eligibility staff to document exception request information. No identifying information should be documented on this form.

Date of Request	Client ID#

Name of Agency	Address

Eligibility Staff	Phone Number

Check the eligibility requirement in question:

Proof of HIV	☐
Living in Florida	☐
Medicaid/other program participation (Payor of last resort)	☐
Income	☐
Willingness to cooperate	☐

Check the reason for the exception request:

To prevent the loss of health insurance benefits, or	☐
To prevent hospitalization, or	☐

Both exception criteria must apply:

An emergency situation	☐
A short term circumstance (less than 180 days)	☐

Justify the exception to the eligibility requirement based on the criteria above: (narrative)

Signature	**Concur**	**Do Not Concur**
Supervisor	☐	☐
Lead Agency Staff	☐	☐
HAPC or designee	☐	☐
BOHA Staff	☐	☐

The original form signed by all parties must be kept in the client file.