ATTACHMENT H

Notice of Ineligibility

Date	Client Name/Address

It has been determined that you are ineligible to receive allowable services from the Florida Department of Health, Ryan White Part B Program, for the following reason(s):

☐ You are not HIV positive.	☐ Your gross income is above 400% of the Federal Poverty Level (FPL).
☐ You are not living in Florida.	☐ You are unwilling to sign all forms and provide the appropriate eligibility information.
☐ You are not willing to utilize your private or other third party insurance.	☐ Other (specify):

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

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

If you want to contest this ineligibility decision, you may petition for an administrative hearing (appeal) pursuant to Sections 120.569 and 120.57, Florida Statutes. Such proceedings are governed by Rule 28-106.201 or 28-106.301, Florida Administrative Code. The petition must be in writing and must be received by the Agency Clerk within twenty-one (21) days of your receipt of this decision. Mediation is not available as an alternative remedy. Failure to submit a petition for hearing within the 21-day limit waives your right to an administrative hearing, and this decision becomes a "final order." A written petition may be sent to:

Office of the General Counsel
Attn: Agency Clerk
Florida Department of Health
4052 Bald Cypress Way
BIN #A02
Tallahassee, FL 32399-1703

Eligibility Staff Signature: _____ **Date:** _____

Eligibility Staff Name	Agency Name, City, State	Phone

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