FLORIDA DEPARTMENT OF HEALTH

Request for Exception

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.