

**INSURANCE SERVICES PROGRAM
NOTICE OF CHANGE FORM**

Date: _____

Please **CHANGE** the following information regarding my client _____

RWIS # _____, who is either enrolled in or wait-listed for services through the *Insurance Services Program* administered by The Health Councils, Inc.

Please **DISENROLL** my client from program services (*do not complete other information; just sign, date, and return form*)

My client (check one): is on HIV drug therapy is not on HIV drug therapy

CLIENT DEMOGRAPHICS							
<i>(please CHANGE the following information per the codes specified in County MAR memorandum)</i>							
Social Security Number		Gender	Ethnicity	Race	Income	Housing/Living Arrangements	
Medical Insurance	HIV/AIDS Status	Enrollment Status		DOB	Exposure		
COUNTY OF RESIDENCE (check one):							
<input type="checkbox"/>	Hardee	<input type="checkbox"/>	Highlands	<input type="checkbox"/>	Manatee	<input type="checkbox"/>	Pinellas
<input type="checkbox"/>	Hernando	<input type="checkbox"/>	Hillsborough	<input type="checkbox"/>	Pasco	<input type="checkbox"/>	Polk

I attest that I have personally reviewed all appropriate documentation required to make the change in demographics specified above.

CASE MANAGER'S SIGNATURE AGENCY PHONE # FAX #

PLEASE RETURN BY MAIL OR FAX TO:
The Health Councils, Inc. Attention: Barbara Hay
9600 Koger Boulevard, Suite 221 St. Petersburg, Florida 33702 FAX (727)570-3033