

**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.

Demographic Change (Note on Client Demographics)

Insurance Policy Change (Attach copy of client's new health insurance policy benefit summary, including a description of pharmacy benefits)

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 #