



Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Executive Office of Elder Affairs

## Home Care Program Notice of Eligibility/Copayment

Applicant:

Aging Services Access Point (ASAP):

---

---

---

---

---

---

Based on a review of your application, we have determined that you are **eligible** to receive Home Care Program services.

Your monthly copayment for these services will be: \$\_\_\_\_\_.

**This is not a bill. You will receive a bill after the services are provided.**

Please notify your case manager of any change in service need, living arrangement, or income.

Case manager:\_\_\_\_\_

Date:\_\_\_\_\_

Telephone number:\_\_\_\_\_