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

Home Care Program
Notice of Eligibility/Voluntary Copayment

Applicant:

_____

_____

_____

Aging Services Access Point (ASAP):

Central Boston Elder Services, Inc.

2315 Washington Street

Boston, MA 02119

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

If you wish to make a **voluntary copayment** toward the cost of your services, the suggested monthly donation is $_____.

If you choose not to make a voluntary copayment, your services will **not** be affected.

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

Case manager:_____ Date:_____

Telephone number:_____