



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):
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.

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: _____