# HOPWA Single Provider Statement

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have requested to receive **HOPWA** services at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agency.

I understand that HOPWA program participants may not receive financial assistance from “multiple sources for the same purpose within the same time period, and the total assistance received for that purpose is more than the total need for assistance;” this includes duplicative HOPWA and Ryan White benefits for the same purpose within the same time period. By signing I state that I will not receive duplicative assistance from another organization.

I understand that I cannot receive any Ryan White Part B services at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agency until I have terminated my current Ryan White Part A services at another organization.

I understand that receiving the same services at two organizations may result in loss of services completely.

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Client Print Sign Date

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Staff Print Sign Date