

PRESUMPTIVE ELIGIBILITY (PE) CFI/HCBC APPLICATION COVER SHEET FOR MEDICAID

COMMUNITY PARTNERS USE ONLY

Applicant Information

Please Print

Applicant Name: _____

Address & Telephone Number: _____

Contact Person Name: _____

Address & Telephone Number: _____

Checklist of Eligibility Forms and Verification Attached to This Cover Sheet

- | | |
|--|--|
| <input type="checkbox"/> Form 800, Application | <input type="checkbox"/> Form 788, Authorized Representative |
| <input type="checkbox"/> Form 811S, Statement of Understanding | <input type="checkbox"/> Citizenship & Identity Verification |
| <input type="checkbox"/> Income, Resources and Residency | <input type="checkbox"/> Legal Liability Form |
| <input type="checkbox"/> Form 1002 PE CFI HCBC | <input type="checkbox"/> Form 1003 PE CFI HCBC |
| | <input type="checkbox"/> Form 770 Reimbursement Agreement |

Checklist of Medical Information Attached to This Cover Sheet

- | | |
|--|--|
| <input type="checkbox"/> Form 177, Non-Medical Evaluation | <input type="checkbox"/> Form 900, Authorization to Release Medical Information (1 per provider) |
| <input type="checkbox"/> Verification of application for Social Security | <input type="checkbox"/> Medical Eligibility Determination Application Form – for Choices For Independence must be signed by applicant or guardian |
| <input type="checkbox"/> Medical records | |

Community Partner (please print)_____
Phone Number_____
Date

SERVICELINK/FSS USE ONLY

SLRC received the application on: Received on: _____ the 20 business days ends _____.
(The date that SLRC receives and date stamps the application packet is the date the 20 day clock begins)

Stamp HerePE application was complete with all the forms(s) 1002, 1003, 1004, 900's 177 ☐ yes ☐ noContacted Community Partner for missing forms(s) ☐ yes ☐ noPE application given to the FSS/Supervisor ☐ yes ☐ no _____ (date)

Remaining verifications due by: _____ (date) All verifications received: _____ (date)

☐ Faxed to 271-7985 (BEAS) on _____ (date)☐ Eligibility PE Effective dates: From: _____ to: _____☐ Ineligible Reason: _____

Medicaid ID# _____

☐ Copy provided to SLRC☐ E-Mail sent to BEAS

Signature of FSS: _____ Date: _____

NOTES: