# APPLICATION FOR MEDICAID PRESUMPTIVE ELIGIBILITY (PE)

Medicaid eligibility determined via this PE application is temporary. If an application for full Medicaid is not filed by the end of the month after the month of this PE determination, the PE period and coverage will end on that day.

## A. Please tell us about the PE applicant and where the PE applicant lives.

***If you are applying for PE on behalf of someone else, tell us about that person's information in Section A below, not your own information.***

PE Applicant's Legal Name: _____ Primary Language: _____

Street Address: _____ Mailing Address: _____
(if different from street address or if confidentiality is needed)

City/State/Zip: _____ _____

If no permanent address, please tell us where the PE applicant can be reached: _____

E-Mail Address: _____ ☐ No E-Mail address

Primary Phone: _____ Secondary Phone: _____

## B. Please tell us about your family. Include your spouse and your children under the age of 19 if they live with you. *Do not list other relatives or friends even if they live with you.*

| Name | SSN (optional) | DOB | Relationship to you | Only answer these questions for the individuals applying for PE on this application. U.S. Citizen, U.S National, or Eligible Immigrant | NH Resident | Medicaid Recipient |
|---|---|---|---|---|---|---|
| | | | **Self** | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | | | | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | | | | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | | | | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | | | | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |

Is anyone pregnant? ☐ Y ☐ N **If yes,** who? _____

How many babies are expected? ☐ 1 ☐ 2 ☐ 3 ☐ Other _____

Did any of these individuals age out of New Hampshire foster care? ☐ Y ☐N

**If yes,** who? _____

Have any individuals applying for PE been approved for PE during this calendar year? ☐ Y ☐ N

**If yes,** who: _____

Have any pregnant individuals applying for PE been approved for PE during this current pregnancy? ☐ Y ☐ N

**If yes,** who: _____

Do any of the individuals applying for PE get Medicare? ☐ Y ☐ N

**If yes,** who: _____

Are any individuals applying for PE parents or caretaker relatives? ☐ Y ☐ N **If yes**, complete section ***C*** on the back.

**PLEASE COMPLETE & SIGN THE BACK**

## C. Please tell us about any individuals applying for PE who are parents or caretaker relatives.

| Name | Unemployed? | Disabled or Temporarily Incapacitated? | Working less than 100 hours per month? |
|---|---|---|---|
| | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |
| | ☐ Y ☐ N | ☐ Y ☐ N | ☐ Y ☐ N |

## D. Please tell us about your family's income. *Include all cash the individuals get from working, self-employment, spousal support, unemployment, tips/commissions, pensions, disability, & cash gifts from friends/family.*

| Name of Person Receiving Money | Name of Agency, Employer, or Individual that Provides the Money | Amount Received | How Often? |
|---|---|---|---|
| | | $ | ☐ Weekly<br>☐ Bi-Weekly<br>☐ Monthly |
| | | $ | ☐ Weekly<br>☐ Bi-Weekly<br>☐ Monthly |
| | | $ | ☐ Weekly<br>☐ Bi-Weekly<br>☐ Monthly |
| | | $ | ☐ Weekly<br>☐ Bi-Weekly<br>☐ Monthly |

## E. Signatures

**I certify, under penalty of unsworn falsification pursuant to RSA 641:3**, that I have reviewed the information on this form, it is true and complete to the best of my knowledge, including the information concerning citizenship/immigration status and prior presumptive eligibility periods.

PE Applicant Signature _____ Date _____

If someone helped the PE applicant complete this form, that individual must sign below.

Signature _____ Legal relationship to PE applicant _____ Phone # _____

## FOR CERTIFIED PE WORKERS ONLY

**The following individuals have been determined eligible for PE:**

| Name | FPMA Only? | PE Begin Date (mm/dd/yy) |
|---|---|---|
| | ☐ Y ☐ N | |
| | ☐ Y ☐ N | |
| | ☐ Y ☐ N | |
| | ☐ Y ☐ N | |
| | ☐ Y ☐ N | |

I certify, under penalty of RSA 167:61-b, that I have explained to the applicant what PE is, and that if I determined the applicant presumptively eligible:

- I have been trained and certified by DHHS to make this determination of eligibility;
- The individual is eligible based on the information provided to me and my having verified that the individual is not already a Medicaid applicant and is authorized for this PE period; and
- I have recorded the eligibility begin date(s) above.

Signature of Certified PE Worker _____ Date _____ Provider Number _____

Printed Name of Certified PE Worker AND Hospital/Agency _____ Email address _____

Fax to: Main District Office (603) 271-8604; mail to: Main DO, 129 Pleasant St., Concord, NH 03301; or Mail to any District Office