

Request to Determine Presumptive Eligibility (PE)

Presumptive eligibility (PE) ensures that an individual can be immediately enrolled in Medicaid on a temporary basis if, after the collection of limited, preliminary information, it appears he or she is eligible. PE also ensures reimbursement for the services provided. Completing this form and signing your name at the bottom, means that you are interested in attending a training given by DHHS to become certified as a Qualified Hospital (QH) or Qualified Entity (QE) so that you can determine PE. This form also serves as your request to DHHS to become a QH or QE.

Your Name: _____ Email: _____

Your Title: _____ Phone No: _____

Hospital/Provider Name: _____ Fax: _____

Address: _____ Preferred Method of contact:
 Email Fax Phone

I understand that becoming a certified QH or QE means all of the following:

- ✓ I must be enrolled as a Medicaid provider with DHHS. 42 CFR 435.1101
- ✓ Every employee who will be making PE determinations must first be certified by DHHS. To become certified, employees must attend a DHHS training and pass a written test with a score of at least 85%. Only the individuals who have been certified by DHHS will be able to determine PE. PART He-W 843
- ✓ Only employees of the QH/QE may be certified to perform PE determinations. Third party contractors or vendors you use will not be allowed to perform PE determinations. PART He-W 843
- ✓ I agree to apply PE eligibility requirements consistently and accurately during every PE determination, per 42 CFR 435.1101-42 CFR 435.1110 and PART He-W 843. I understand that I am responsible for ensuring that the PE applicant is not already enrolled in Medicaid and that the individual is authorized for each PE period I approve.
- ✓ DHHS will monitor successful attainment and maintenance of my adherence to the standards required to obtain and retain certification to determine PE. Failure to maintain the certification requirements will require additional training and testing and may result in the disqualification of my PE certification. If my certification is suspended, I will no longer be allowed to determine PE during the suspension period. PART He-W 843.

FOR QH ONLY: I understand that becoming a certified QH also means the following:

- ✓ I must additionally meet and maintain the following performance standard to retain certification: 75% of the people for which I have made a PE determination must submit a full Medicaid application before the end of his or her PE period. This means that I will be expected to assist individuals in completing and submitting the full Medicaid application and must, therefore, understand and be able to explain all documentation requirements. DHHS will monitor successful attainment and maintenance of this performance standard. Failure to meet and maintain this standard may result in the disqualification of my QH certification.

I am notifying you that I want to become a certified QH or QE to determine PE for:

- Medicaid and (optional) Family Planning Expansion Category (FPEC) # to attend training: _____
- FPEC – ONLY** # to attend training: _____ **Note:** For FPEC training, a billing employee *must* attend.

Signing below indicates I understand the requirements and responsibilities for being certified and I am notifying DHHS that I wish to be trained to determine PE.

Signature [must be the same person identified in the Name field above]

Date

Send this completed form to DHHS using **one** of the following methods:

Fax to: 603-271-0647 **OR** **Mail to:** Bureau of Family Assistance (BFA), Training Unit, 64 South Street, Concord, NH 03301-3612