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. *Write the total income before taxes are taken out for all family members in section B.*

	Amount Received	How Often?
Job Income *For example, wages, salaries, tips, commissions, and self-employment income.*	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly
Other Income *For example unemployment checks, spousal support, disability benefits. Do **not** include Supplemental Security Income ("SSI payments") or any child support you receive.*	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly

E. Signatures

I certify, under penalty of perjury, 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