Patient Record # _____
Date Care Initiated _____

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Eligible _____ Ineligible _____
Due Date_____

PRESUMPTIVE ELIGIBILITY DETERMINATION FORM FOR PREGNANCY – RELATED CARE

Patient Information: Address _____ County _____ Phone _____ E-Mail _____
Street Address City State Zip

Household Members:

Line No.	HOUSEHOLD MEMBERS								TAX FILING STATUS				
	NAME (First, MI, Last)	DATE OF BIRTH (mm/dd/yyyy)	RELATIONSHIP TO APPLICANT	SEX	RACE* (optional)	ETHNICITY** (optional)	SOCIAL SECURITY # (optional)	NC RESIDENT? (y/n)	Will this person file federal income taxes for current year?	Claimed as tax dependent on current year's tax return? (y/n)	If tax dependent, who will claim?	Meet any tax exceptions?	Claim anyone not living in home? If so, who?
1													
2	UNBORN CHILD												
3													
4													
5													
6													

*Asian = A American Indian or Alaska Native = I Native Hawaiian or other Pacific Islander = P Caucasian or White = W Black or African American = B Unreported = U
**Not Hispanic/Latino = N Hispanic Cuban = C Hispanic Mexican = M Hispanic Puerto Rican = P Hispanic Other - H

Financial Eligibility Information:

TOTAL COUNTABLE MONTHLY INCOME = $	NUMBER IN HOUSEHOLD:	POVERTY INCOME LEVEL: $

Health Insurance Information (optional):

Company Name	Policy Holder's Name	Policy Number	Group Number	Insurance Type(s)	Policy Begin Date

I attest that I am pregnant with _____ fetus (es). I understand that this is a temporary determination of my eligibility for Medicaid and that if I do not file an official application for Medicaid by the last day of the month following the month this form is signed my eligibility will stop on that date. I also understand that I am eligible only for outpatient prenatal care related to my pregnancy. I certify that I have provided true and accurate information about my household, income, and state residency.

The federal government requires the State to provide information about your language preference. Please help us by providing the language you prefer to speak (circle one) English Spanish Other Specify_____

_____ _____
Application Date Applicant's Signature

_____ _____ _____ _____
Provider Name/NPI # Completed by (print): Title Signature/Date

INSTRUCTIONS FOR PROVIDER:

I. General
- A. Use black ink.
- B. Complete 3 copies.
- C. Mail or deliver to the County DSS of the applicant's county of residence no later than 5 working days after the presumptive determination.

II. Patient information
- A. Give the date prenatal care was initiated for this pregnancy.
- B. Give the pregnant woman's current mailing address.
- C. Indicate the name of the county to which the DSS referral will be sent.
- D. Document whether patient was determined eligible or ineligible for presumptive eligibility.

III. Household members – Refer to Administrative Letter 18-13 for instructions on how to determine family size.
- A. Enter family members names in the following order:
  1. Pregnant woman
  2. Pregnant woman's spouse, if married.
  3. Other household members
- B. Birth date of the pregnant woman is required. Optional for other household members.
- C. Enter household member's relationship to the pregnant woman.
- D. Enter sex code for each member.
- E. Optional: Enter the pregnant woman's race, ethnicity, and social security number. Social security numbers are not required for non-applicants.
- F. Indicate if individual is a resident of NC.
- G. Enter Tax filing status for all family members.

V. Financial Eligibility Information
- A. Enter total monthly income from DMA-5034.
- B. Record number in household. Refer to Administrative Letter 18-13 for instructions on how to determine family size.
- C. Record Poverty Income Level for number in household in designated block. If Total Gross Income is equal to or less than Poverty Income Level for number in household - STOP. Pregnant woman is presumptively eligible.

IV. OPTIONAL: Provide requested information on health insurance coverage for the pregnant woman only. If the woman states she has no insurance, write NONE. If space is needed for more than two policies, attach additional sheet. Health insurance coverage includes these types:

Major Medical	Basic Hospital/Surgical	Basic Hospital	Dental Only	Cancer Only	Nursing Home Only	Medicare Supplement
Intensive Care	Physician Only	Major Medical+Dental		Vision Care	Heart Attack Only	Indemnity
Prescriptions Only						
Major Medical+Nursing Home	Hospital Outpatient Only	Accident Only				

VI. Signatures
- A. Enter application date
- B. Obtain the pregnant woman's signature and date of signature.
- A. Enter provider's name and provider's NPI number.
- B. The person completing the DMA-5032 must sign and enter the date presumptive eligibility determined.