HOSPITAL PRESUMPTIVE ELIGIBILITY TRANSMITTAL FORM

SECTION I: TO BE COMPLETED BY PROVIDER

PROVIDER NAME AND NUMBER: ____

BENEFICIARY NAME: ____

DATE: _________________________________

You have been found temporarily eligible for Medicaid under the following program:

☐	Pregnant Woman (MPW)	☐	Infants and Children (MIC)
☐	Family Planning Program (MAF-D)	☐	Families with Dependent Children (MAF)
☐	Former Foster Care Children (MFC)	☐	Breast and Cervical Cancer (MAF-W)

You must apply for Medicaid no later than ___________. If you do not apply for Medicaid by this day, your eligibility will stop on the last day of that month. You may apply in any of the following ways:

1. On-line at https://epass.nc.gov/CitizenPortal/application.do
2. Print and complete a paper application, located at http://www.ncdhhs.gov/dma/medicaid/applications.htm and mail or take to ______________________ County Department of Social Services.
3. Visit the _______________ County Department of Social Services to apply in person.

FOR PREGNANT WOMAN ONLY: If you do apply for Medicaid for pregnant women you may be eligible to receive Medicaid coverage for all pregnancy related services (including delivery) up to and for 60 days after the end of your pregnancy. Please apply for Medicaid as soon as possible so that you do not lose potential benefits and you can receive Medicaid throughout your pregnancy.

Information you may need to provide the Department of Social Services (DSS) for establishing your eligibility is listed below.
If you do not have all the information, take what you have. **Do not delay applying if you do not have the information.**

1. Birth Certificates or other proof of citizenship and identity when applying for Medicaid for yourself.

2. Proof of residency in North Carolina, such as a driver's license, motor vehicle registration or rent receipt.

3. Proof of income for the previous calendar month for your household.

4. Social Security Card or Number for all applicants.

Note: Anyone who wants to receive Medicaid or Health Choice benefits must give us his social security number. If you do not have a social security number, you must apply for one to receive benefits. **Persons applying for Emergency Medicaid services only are not required to provide a social security number, documentation of citizenship or immigration status.**

SECTION II: TO BE COMPLETED BY COUNTY DSS

COUNTY ______________________________ MID ________________________________

_____ 1. Did not apply by ___________________. Presumptive eligibility authorized from
______________________ through ________________________.

_____ 2. Did apply by ____________________. Date of application is __________________.

_____3. Medicaid application is:

______ Approved; Medicaid eligibility authorized effective ________________.
______ Pending; due to ____.
______ Denied/Withdrawn; due to ____________________________________.
______ Presumptive eligibility is authorized from _______________________
through __________________________.

____

DATE INCOME MAINTENANCE CASEWORKER

Instructions for Completion of Presumptive Eligibility Transmittal Form

1. Complete 4 copies: original and 1 copy – County DSS
   cc: Provider
   cc: Applicant

2. Complete the applicant's name, provider name and ID number, and the date the form is completed.

3. Enter the appropriate county DSS. This must be the county in which the applicant resides.

4. Enter the date, which is the last workday of the month following the month the Presumptive Eligibility Determination Form is signed.

5. Give a copy to the applicant.

6. Send the original and one copy to the county DSS within 5 workdays from the date the Presumptive Eligibility Determination Form was signed.

7. Retain one copy for your records.