



IDAHO DEPARTMENT OF

HEALTH & WELFARE

Presumptive Eligibility Medicaid Training

Idaho Department of Health and Welfare (DHW), Division of Self-Reliance

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Starting the customer conversation

What is Presumptive Eligibility Medicaid

Presumptive Eligibility Medicaid is immediate, temporary health coverage for eligible individuals receiving care. This coverage is short term, but the application will also be used to determine a customer's eligibility for long-term health coverage.

Who can receive coverage?

Customers are determined eligible by a hospital representative, based on the customer's household size, income, immigration status, medical need, or age. See the [Populations for Presumptive Eligibility Medicaid](#) section of this training for more specific information.

Customers can receive Presumptive Eligibility Medicaid only once within a 12-month period, or once per pregnancy. A pregnant woman may be eligible more than once in a 12-month period, as they will be able to receive coverage during each pregnancy.

What does the customer need to know?

When a customer applies for Presumptive Eligibility Medicaid, it is important that you discuss the requirements and limitations of coverage. This application will be used by DHW to determine eligibility for any Health Coverage Assistance program, including Medicaid and the Children's Health Insurance Plan (CHIP).

The customers' coverage is valid until a certain date and will then end unless and the customer is determined eligible for longer-term Medicaid by DHW. The customer should also be informed that DHW will use integrated tools to verify a customer's immigration status and income. Additional verification documents may be requested by DHW.

If the customer has children living with them, and you have determined they are eligible for PE, let them know the Department of Health and Welfare will ask about a child's parent not living in the home. Explain that this information is provided to Child Support Services, who may pursue a Child Support case if the customer is determined eligible.

Populations for Presumptive Eligibility Medicaid

The following populations are eligible for Presumptive Eligibility Medicaid coverage if they meet the income criteria and the groups below:

- Children under 19
- Former Foster Care Children (ages 18 through 25)
- Parent/Caretaker Relative Medicaid
- Pregnant Woman (Ambulatory Prenatal Care only)
- Breast and Cervical Cancer
- Individuals ages 19-64

Immigrant Applicants

Immigrant applicants are considered eligible if any of the following applies:

- Lawful Permanent Residents /Green Card Holder **
- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Children lawfully residing in the state of Idaho (lawfully present and otherwise eligible for CHIP in the state, including being a state resident)

***Most adult Lawful Permanent Residents or Green Card holders have a 5-year waiting period before being eligible for Medicaid. Contact the Idaho Department of Health and Welfare to determine if this applies to your customer.*

Qualified Non-Citizens

- The client will be required to provide information at the time of the application that their 5-year waiting period has been completed
- If the client doesn't have that information with them at the time of visit, the QE's will let the client know that they need to provide verification of their status within 10 days for the application to be approved
- If the client cannot provide the needed information or does not meet the requirement, the request for PE coverage will be denied.
- When the application is provided to DHW for the Qualified Non-Citizen, attach the front and back of the immigration and verification documents.

Coverage Types

Children's Health Insurance Program (CHIP)

- Children up to age 19.
- Applicants cannot have other health insurance and receive CHIP.

Former Foster Care

- For individuals who were in Foster Care through the state of Idaho and receiving Medicaid when they turned 18.
- May apply if currently age 18 through age 25.
- No Income limit or resource/asset test.
- Should be evaluated for PE as an individual even if living in a household with other family members.

Parent/Caretaker Relative Medicaid

- For individuals who live together and are related by marriage or parentage.
- The parent or caretaker relative must be responsible for a related dependent child under age 19 who is living with them in the home to be eligible.

Pregnant Woman

- For pregnant women presenting for services prior to delivery.
- A pregnant woman may be eligible for Presumptive Medicaid more than once in 12 months if they are pregnant more than once in that 12-month period.

Individuals 19 – 64

- For individuals between the ages of 19-64.
- Not pregnant at the time of application.
- Not eligible for or enrolled in Medicare Part A.
- Not enrolled in Medicare Part B.
- For parents and caretakers not income eligible for the Parent/Caretaker Relative Medicaid listed above.

Breast and Cervical Cancer

- For women (ages 19 through 64) presenting for services after screening at a designated Women's Health Check facility AND after receiving diagnosis and treatment options for breast and/or cervical cancer.
- Millennium Pre-approval form, the Presumptive Eligibility Medicaid Form, Idaho Women's Health Check Enrollment form, and appropriate verification documents must be presented to DHW to be eligible for PE.
- Income and household size do not need to be evaluated they are reviewed during the Breast and Cervical Cancer Screening process.
- Applicants cannot have other insurance which covers breast or cervical cancer treatment.

Presumptive Eligibility Medicaid Application Process

Step 1 – Verify Coverage Status

Partner Data Access Portal: <https://pdap.dhw.idaho.gov>

If you do not have access to PDAP, a hospital supervisor should email PartnerAccess@dhw.idaho.gov to get set up with a PDAP account.

In PDAP, verify if the person has current coverage.

In this example, the person has AABD coverage:

The screenshot displays two panels from the PDAP interface. The left panel is titled 'HCA' and shows 'HCA Eligibility: Eligible' in a green box. Below this, it lists 'HCA Re-Evaluation Due: 12/2017', 'MEDICAID Aid Code: 51' with description 'Aid to the Aged', and 'MEDICAID Aid Code: 68' with description 'Medicare Savings Program'. The right panel is titled 'SNAP' and shows 'SNAP Eligibility: Participating' in a green box. Below this, it lists 'SNAP Re-Evaluation Due: 02/2017' and 'SNAP Benefit Amount: \$220.00'. A third panel titled 'TAFI' is partially visible at the bottom right.

Persons currently covered under Medicaid or CHIP do not need Presumptive Eligibility Medicaid. Those who had Presumptive Eligibility Medicaid within the past 12 months (with a PE effective date on or after a year prior to the current date), and who are not pregnant, are not eligible for PE, but the Application for Health Coverage Assistance should still be offered.

Step 2 The Presumptive Eligibility Medicaid Application

You, as the hospital representative, complete or assist the customer in completing, the *Presumptive Eligibility Medicaid* application. Skip the -Hospital Only- Eligibility Criteria section on the bottom of the cover page until after the application is complete.

Start by explaining the application, what information you will use to determine eligibility, and present the customer with a copy of the Accessibility and interpretation services page, should they require assistance.

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Presumptive Eligibility Medicaid

Presumptive Eligibility Medicaid allows approved healthcare providers to give access to temporary Medicaid coverage to individuals who appear eligible. This form should be used when applying for Health Coverage Assistance through the Idaho Department of Health and Welfare. It is not possible.

WHO can use this application	Hospital representatives and customers can use this form to apply for Presumptive Eligibility Medicaid.
WHAT you may need to apply	<ul style="list-style-type: none"> Employer and income information for everyone in the customer's family (for example pay stubs, tax returns, or other wage and tax statements) Social Security numbers for dependent members for legal minors Proof of identity (for example driver license or passport)
WHEN to use this application	<p>Use this application if a customer is in need of medical services, does not have current health coverage, and meets the criteria below:</p> <ul style="list-style-type: none"> Customer is an Idaho citizen/legal permanent resident Customer income is at or below the monthly income limit for Medicaid Customer has not received Presumptive Eligibility Medicaid coverage in the past 24 months Customer has not received Presumptive Eligibility Medicaid for this term of pregnancy Customer meets one of the following criteria: <ul style="list-style-type: none"> Customer is a child under the age of 19 Customer is a parent or caretaker relative of a minor child Customer is a pregnant woman Customer is an adult 19-64 years old, not receiving Medicaid Customer is 19-24 years old and received Idaho Medicaid through the foster care program on their 18th birthday
Equal opportunity for applicants	<p>In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare (IDHW) is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Idaho Department of Health and Welfare does not exclude people or treat them differently because of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS or IDHW at:</p> <p>Idaho Department of Health and Welfare Civil Rights Manager P.O. Box 83720 Boise, ID 83720-0084 Fax: 202-490-7442 Email: peprogram@idaho.gov</p> <p>U.S. Department of Health & Human Services Room 5045, 300 Independence Avenue, SW Washington, D.C. 20501 Email: OCR@hhs.gov Phone: 202-619-0083 (voice) 202-619-1237 (TDD)</p>
HOW to submit this application	Call the Idaho Department of Health and Welfare (IDHW) to submit this application 1-877-456-1233 Monday - Friday, 8:00 am - 5:00 pm.

Eligibility Criteria - Hospital Use Only -

Select all eligibility criteria that apply to the applicant. All statements must be true for the applicant to be determined eligible.

<input type="checkbox"/> Applicant is an Idaho resident	<input type="checkbox"/> If pregnant, applicant has not received Presumptive Eligibility Medicaid for this term of pregnancy
<input type="checkbox"/> Applicant meets residence or citizen requirements	<input type="checkbox"/> Applicant meets one or more of the following requirements (select all that apply)
<input type="checkbox"/> Applicant's household income is within the income limit	<input type="checkbox"/> Is a child under age 19
<input type="checkbox"/> Applicant has not received Presumptive Eligibility Medicaid in the last 24 months	<input type="checkbox"/> Is a former foster care child
	<input type="checkbox"/> Is a pregnant
	<input type="checkbox"/> Is a parent/caretaker relative
	<input type="checkbox"/> Is an adult age 19-64 without Medicare

Accessibility and interpretation services

The Idaho Department of Health and Welfare (IDHW) offers the following services free to you. Please ask if you need the following assistance to communicate more effectively with us:

- Assistance in understanding this form
- Accommodation for a disability
- Language Interpreter

To access any of these services, please call 1-877-456-1233 (toll free) or 1-800-377-3529 (TDD) or 1-800-377-1363 (voice) for those with a hearing impairment.

English	ATTENTION: Language assistance services, free of charge, are available to you. 1-877-456-1233.	T Filipino (Tagalog)	PAUNAWK: Kung nagpapalili ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-456-1233.
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-456-1233.	Russian (Русский)	ВНИМАНИЕ: Если вы предпочитаете русское общение, то вам доступны бесплатные услуги интерпретации. Позвоните 1-877-456-1233.
繁體中文 (Chinese)	(注意) 如果您使用繁體中文，您可以免費獲得語言協助服務。請致電 1-877-456-1233。	French (Français)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-456-1233.
Slovenščina (Slovene)	OBRAVNIŠTINE: Ako govorite slovenski, vasilje jaskič pomoči dostopne su vam besplatno. Nazovite 1-877-456-1233.	Japanese (日本語)	注意書き: 日本語を母語とする場合は、無料の言語支援サービスをご利用いただけます。1-877-456-1233まで、お電話にてご連絡ください。
한국어 (Korean)	주의: 한국어로 서비스를 이용하실 경우, 언어 지원 서비스는 무료로 이용하실 수 있습니다. 1-877-456-1233 번호로 전화하십시오.	Romanian (Romanian)	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică gratuită. Sunați la 1-877-456-1233.
አማርኛ (Amharic)	ጥቅም: የአማርኛ ቋንቋ ለመገናኛ ስራዎች ለማድረግ ለደንበኞቻችን የሚሰጠው አገልግሎት ከገንዘብ ጋር የተያያዘ አይደለም። ይህንን አገልግሎት ለማግኘት 1-877-456-1233 ድምር ያድርጉ።	Kiswahili (Kiswahili)	ACHIONGEWA: Nimba kwamba Kiswahili, usohabwa serivisi ya guthaka msa ndemi, ku buswa. Watoteleza 1-877-456-1233.
Tiếng Việt (Vietnamese)	CHÚ Ý: Các bạn nói Tiếng Việt có thể dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-456-1233.	فارسی (Farsi)	توجه: اگر شما فارسی را به عنوان زبان مادری خود می‌بینید، خدمات ترجمه رایگان در دسترس شماست. با شماره 1-877-456-1233 تماس بگیرید.
العربية (Arabic)	ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات الترجمة اللغوية متاحة لك مجاناً. اتصل على الرقم 1-877-456-1233.	Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-456-1233.

Appeal/Hearing rights

You have the right to ask for a hearing if you disagree with the decision made by the Idaho Department of Health and Welfare. You have 90 days to ask for a hearing for the Supplemental Nutrition Assistance Program (SNAP), and 30 days for Temporary Assistance for Families in Idaho (TAFI), Idaho Child Care Program (ICCP), Aid to the Aged, Blind, and Disabled (ABBD) cash, Medicaid, and Advance Payment of Premium Tax Credit (APTC). These timeframes start the day after IDHW gave or mailed you a notice of the action with which you disagree. Please be advised that a re-evaluation of eligibility will be assessed for all members of the household at the time this appeal is considered.

To request a hearing or a legal aid referral:

- Call 1-877-456-1233
- Email us at MyIDHW@idaho.gov
- Fill out and submit the Fair Hearing Request Form at mybenefits.dhw.idaho.gov.

At the hearing, you may represent yourself or use legal counsel, a relative, a friend, or other spokesperson to represent you.

idahoink
idahoink is Idaho's online self-service website where you can view information about the benefits you receive, report a change, and apply for other programs offered by IDHW. Registering is easy. Visit idahoink.idaho.gov to get started today!

When completing this application, you will first fill out the page about the primary applicant, or the applicant who will be the primary point of contact.

Tell us about yourself

You will be the primary contact person for this application, even if you may not be applying for assistance for yourself. Information that is optional or not required:

- U.S. citizenship status - optional for people not applying for assistance
- Race - optional
- Social Security number - optional for people not applying for assistance
- Hispanic or Latino - optional

1. Are you applying for Health Coverage Assistance (HCA) for yourself?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
2. Full name	First	Middle	Last		
3. Former names (if any)	First	Middle	Last		
4. Physical address	Street	City	State	Zip	County
5. Mailing address (if different)	Street	City	State	Zip	County
6. Email					
7. Primary phone	Phone type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work				
8. Social Security number	If none, what number may we use to leave a message?				
9. Date of birth					
10. Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female				
11. Marital status	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Never been married				
12. Pregnant	<input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.				
	a. Due date?		b. How many are you expecting?		
13. Preferred language	Spoken		Written		

Then list anyone in the applicant's household. You may need to make copies of this page if the customer has more than two household members.

Tell us about everyone in your household

Who you need to include on this application:

- Regardless of the types of assistance you apply for, we need information about everyone in your household.
- If applying for health coverage assistance for anyone under 65 and not disabled, we need information about everyone you plan to include on your federal tax return this year, even if they don't live with you.

Note: You do not need to file taxes to get health coverage.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
1. <input type="checkbox"/> No <input type="checkbox"/> Yes	1. Is this person applying for HCA?	1. <input type="checkbox"/> No <input type="checkbox"/> Yes
2. <input type="checkbox"/> No <input type="checkbox"/> Yes	2. Lives at the same address as you?	2. <input type="checkbox"/> No <input type="checkbox"/> Yes
3.	3. Relationship to you	3.
4. First _____	4. Name	4. First _____
Middle _____		Middle _____
Last _____		Last _____
5.	5. Former names, if any	5.
6.	6. Social Security number	6.
7.	7. Date of birth	7.
8. <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Sex	8. <input type="checkbox"/> Male <input type="checkbox"/> Female
9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Never Married	9. Marital status	9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Never Married
10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.	10. Pregnant <small>(Please state)</small>	10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.

Who counts in a household?

For Foster Care

Count only the individual and their income.

For a Pregnant Woman

Include the woman, the unborn child(ren), the father of the unborn (if married and present in the household), and any other children (of the unborn child's married parents) under age 19 who live in the household. For example:

- Ann is a single mother with one child and has a significant other in the household. She is pregnant with one child. For this household, include Anna as the primary applicant, indicate her pregnancy and number of children due on page 1, and list her current child on page 2. Do not count the significant other or his income because he and Ann are not married.
- Mary and her husband, Bob, have 2 children and Mary is pregnant. They are living in the same household with Mary's parents, who require living assistance. For this household, include Mary as the primary applicant, indicate her pregnancy and number of children due on page 1, and list her husband and current children on page 2.

For CHIP, Parent/Caretaker Relative, and Individuals between the ages of 19-64

Include all those on the application connected by marriage or parentage who live in the household, along with unborn children, including natural, adoptive or step parents and birth, adoptive or step children under age 19, as well as unborn children of any of these persons. Do not include other adult relatives who file their own tax return. For example:

- Lily, Rose, and Paul live with their maternal grandparents and are not adopted by the grandparents. Include one of the siblings as the primary applicant on page 1 and list the other two siblings on page 2 (only the income that the children receive would be used for income purposes).
- Susan has three children, including an 18-year old daughter who just had a baby. Her brother Michael and his son live with Susan and her children and grandchild. Include Susan as the primary applicant on page 1 and list her three children and the new baby on page 2. Michael and his son cannot be counted because they are not connected by marriage or parentage.

We will need to know if anyone in the household is or has been in foster care, is currently receiving Medicaid from another state, and if any children in the household currently have some form of health coverage.

Tell us about your household situation			
1. Is anyone in your household applying for or already receiving foster care or adoption assistance?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, who?	
2. Was anyone in your household in Idaho foster care when they turned 18?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, who?	
3. Is anyone in your household currently receiving Medicaid from another state?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, complete a and b.	
a. Dates of assistance	From (month/year):	To (month/year):	
b. Where assistance is received from	City	County	State
Tell us about your health coverage situation			
Does any child (under the age of 19) who is applying for HCA currently receive health coverage?			
<input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b for each child receiving health coverage.			
a. Name of insured child			
b. Covered services (check all that apply)			
<input type="checkbox"/> Inpatient/Outpatient hospital services	<input type="checkbox"/> Lab services		
<input type="checkbox"/> Physicians medical/surgical service	<input type="checkbox"/> X-ray Services		
a. Name of insured child			
b. Covered services (check all that apply)			
<input type="checkbox"/> Inpatient/Outpatient hospital services	<input type="checkbox"/> Lab services		
<input type="checkbox"/> Physicians medical/surgical service	<input type="checkbox"/> X-ray Services		
a. Name of insured child			
b. Covered services (check all that apply)			
<input type="checkbox"/> Inpatient/Outpatient hospital services	<input type="checkbox"/> Lab services		
<input type="checkbox"/> Physicians medical/surgical service	<input type="checkbox"/> X-ray Services		
a. Name of insured child			
b. Covered services (check all that apply)			
<input type="checkbox"/> Inpatient/Outpatient hospital services	<input type="checkbox"/> Lab services		
<input type="checkbox"/> Physicians medical/surgical service	<input type="checkbox"/> X-ray Services		

Collect the customer's and their household members' income information. Inform the customer that income will need to be verified by DHW. Not all income types may apply to the customer, and pieces of this can be left blank.

Tell us about your household income	
Tell us about all taxable income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. We also want to know about income from any job you have just started or will start within the next 30 days. Income types include:	
Earned Wages or salary from:	Unearned Income from sources such as:
<ul style="list-style-type: none"> • Job • Self-employment (including owning your own business, doing odd jobs, baby-sitting, collecting cars, donating plasma, etc.). 	<ul style="list-style-type: none"> • Unemployment benefits • Rental income • Cash gifts • Gaming/lottery payments • Social Security • Retirement income
Income 1	Name of person with income:
Income from a job - Tell us about any income this person gets from working a job.	
Employer's name	Employer's phone number
Average hours worked each week	Wages/tips (before taxes)
How often paid? (check one)	
<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)?	

Step 3 Rights and Signatures

Ask the customer to review their rights and responsibilities on page 5 of the application. The customer should initial next to each statement to confirm that they have read and understood it. Then, the customer or their authorized representative must sign and date the application. After the customer signs the application, you must sign in the field below for the application to be considered valid.

Rights and Responsibilities	
Read and initial each statement below.	
<p><input type="checkbox"/> My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil, or criminal actions against me, including prosecution.</p>	<p><input type="checkbox"/> I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.</p>
<p><input type="checkbox"/> I consent to the gathering, use, and disclosure of my information, including my SSN, by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.</p>	<p><input type="checkbox"/> As part of my application, I understand that IDHW will open a Child Support case and I must cooperate with Child Support Services.</p>
<p><input type="checkbox"/> I have the right to revoke this consent, in writing, at any time, except to the extent the Department has already used and disclosed my information. If I revoke this consent, the Department will not provide further benefits or services.</p>	<p><input type="checkbox"/> This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials, for apprehending persons fleeing to avoid the law.</p>
<p><input type="checkbox"/> My signature indicates I have received a copy of the Department Privacy Practices.</p>	<p><input type="checkbox"/> If I am determined eligible for Medicaid, the plan I will be enrolled in depends on my individual needs.</p>
<p><input type="checkbox"/> I am required to report when my household's monthly income exceeds the gross limit for my household size.</p>	<p><input type="checkbox"/> My signature or the signature of my representative authorizes state offices to communicate with insurance companies related to my/my child's medical assistance.</p>
<p><input type="checkbox"/> I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.</p>	<p><input type="checkbox"/> If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.</p>
<p><input type="checkbox"/> I understand that all adult household members may be responsible for repaying benefits if the household received benefits it was not entitled to receive. This applies to an over-issuance of benefits as a result of an agency error, an inadvertent household error, and intentional program violations. If there is an overpayment of benefits to your household, the information on this application, including all adult SSNs, may be referred to federal and state agencies, as well as private claims collection agencies for collection action.</p>	<p><input type="checkbox"/> I have the right to choose a Healthy Connections primary care doctor to request referrals for services, and to change the doctor/clinic if my circumstances change.</p>
<p>Information available through the Income Eligibility Verification System (IEVS), and other online sources, is used and may be verified through a third-party contact when differences are discovered between the system and what you report. This information may affect your eligibility and level of benefits.</p>	
<p>Applicant Signature (must be completed) Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page and my reporting requirements.</p>	
<p>Printed name of applicant/authorized representative _____</p>	<p>Signature of applicant/authorized representative _____</p>
<p>Date _____</p>	
<p>Hospital Representative Signature (must be completed) Under penalty of perjury, I swear or affirm the information I have provided is true and complete.</p>	
<p>Printed name of hospital representative _____</p>	<p>Signature of hospital representative _____</p>
<p>Date _____</p>	
<p>PEM App Rev. 06/09/2020 Copy this page or attach another sheet if you need to provide more information than space allows. Page 5 of 5</p>	

Step 4 Determine customer eligibility

Based on the information gathered in the application, verify that all eligibility criteria are met according to the requirements on the cover page of the application. Use the *Income Tool*, explained later in this training document, to determine if the customer meets the income criteria, listed on the DHW website: healthandwelfare.idaho.gov.

Eligibility Criteria - Hospital Use Only -	
Select all eligibility criteria that apply to the applicant. All statements must be true for the applicant to be determine eligible.	
<p><input type="checkbox"/> Applicant is an Idaho resident</p>	<p><input type="checkbox"/> If pregnant, applicant has not received Presumptive Eligibility Medicaid for this term of pregnancy</p>
<p><input type="checkbox"/> Applicant meets residency/citizen requirements</p>	<p><input type="checkbox"/> Applicant meets one or more of the following requirements (select all that apply)</p>
<p><input type="checkbox"/> Applicant's household income is within the income limit</p>	<p><input type="checkbox"/> Is a child under age 19</p>
<p><input type="checkbox"/> Applicant has not receive Presumptive Eligibility Medicaid in the last 24 months</p>	<p><input type="checkbox"/> Is a former foster care child</p>
	<p><input type="checkbox"/> Is pregnant</p>
	<p><input type="checkbox"/> Is a parent/caretaker relative</p>
	<p><input type="checkbox"/> Is an adult age 19-64 without Medicare</p>

Step 5 Making a PE Determination

Make and provide a copy of the completed application to the customer.

Based on the answers you made in Step 4 Determine the customer's eligibility.

Customer is **not eligible** for Presumptive Medicaid

If the customer does not meet the eligibility criteria, let them know that they have been denied for Presumptive Eligibility Medicaid.

Print out a copy of the *Presumptive Eligibility Medicaid Notice of Denial*, available on the DHW website at healthandwelfare.idaho.gov, and complete the following:

- Write the Date of Notice, Client Name, and hospital name at the top of the notice.
- Complete and sign the Hospital Representative box, indicating the legitimacy of the document.
- Select the denial reason by marking one or more boxes of the list on the first page of the notice.

Provide the customer with a copy of completed *Notice of Denial* Let them know that they will still be considered for other Health Coverage Assistance programs through DHW if you submit the application. If the customer agrees to submit the application to DHW, follow the steps in the [Finishing the Presumptive Eligibility Medicaid Process](#) section of this training.

Customer is **eligible** for Presumptive Medicaid

If the customer meets all of the eligibility criteria, let them know that they have been approved for Presumptive Eligibility Medicaid.

Print out a copy of the *Presumptive Eligibility Medicaid Notice of Approval*, available on the DHW website at healthandwelfare.idaho.gov, and complete the following:

- Write the Date of Notice, Client Name, and hospital name at the top of the notice.
- Write in the coverage end date in the designated date field. The end date is the last day of the month following the month of application.

For example, if your customer applies for Presumptive Eligibility Medicaid on June 4th, the last day of coverage is July 31st.

- Complete and sign the Hospital Representative box, indicating the legitimacy of the document.

Provide the customer a copy of the completed *Notice of Approval* and let them know that their coverage starts immediately.

Inform the customer that coverage is temporary, but that the application will also be used to determine eligibility for long-term Medicaid and other Health Coverage Assistance programs through DHW.

Print out a copy of the *Proof of Temporary Coverage* letter and complete it according to the instructions of the *Proof of Temporary Coverage* section of this training. Provide the completed letter to the customer and inform them that they must keep the letter and the *Notice of Approval* with them at any time they are receiving care.

Income Calculation

An income calculation tool is available on the DHW website at healthandwelfare.idaho.gov. This tool is designed to help you determine a customer's eligibility according to the income requirements.

After determining the household income, compare that income to the Medicaid income eligibility limit for the customer's household size available on the DHW website at healthandwelfare.idaho.gov. Children under 19 in the household should be determined according to the CHIP income limits.



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DO NOT DOWNLOAD THIS FORM!

Multiple Income Calculator Job Aid

Use the "Multiple Income Calculator Job Aid" to calculate monthly income when a member has income from multiple sources paid at different frequencies. Use the "Total Monthly Income" amount to complete the Presumptive Eligibility Tool screen. Key the total amount to the member using the frequency of monthly. If more than one member has multiple income sources paid at different frequencies, clear the contents and complete the "Multiple Income Calculator Job Aid" for each member this applies to.

Multiple Income Calculator:

Income	Frequency
Total Monthly Income:	\$ -

Proof of Temporary Coverage Form

After determining that the customer is eligible, print out a copy of the *Proof of Temporary Coverage* letter available on the DHW website at healthandwelfare.idaho.gov.



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Presumptive Eligibility Medicaid

Proof of Temporary Coverage

As the recipient of Presumptive Eligibility Medicaid, you must present this letter, along with your Notice of Approval to any doctor or hospital staff from whom you are requesting services.

Dear Provider,

The person(s) listed below is approved for temporary health coverage through Presumptive Eligibility Medicaid in Idaho. Temporary coverage is applicable until the date shown below. To ensure payment, please verify eligibility prior to providing services and submitting claims. You can verify customer eligibility using the Partner Data Access Portal (PDAP).

For more information about Presumptive Eligibility Medicaid, call **1-877-456-1233**.

For more information about PDAP, email **PartnerAccess@dhw.idaho.gov**.

Except for pregnancy services, services included under temporary coverage are the same as those available under regular Medicaid coverage. *Pregnancy services are limited to ambulatory and prenatal care services.*

Recipient name: _____

Date of birth: _____

Coverage: Former foster care Child under 19 Pregnant Parent/Caretaker Relative Individual aged 19-64 Breast & Cervical Cancer

Coverage start date: _____ Coverage end date: _____

Recipient name: _____

Date of birth: _____

Coverage: Former foster care Child under 19 Pregnant Parent/Caretaker Relative Individual aged 19-64 Breast & Cervical Cancer

You will need to list each recipient of coverage. This is not necessarily every member of the household, as it applies only to the individuals receiving care.

Based on the customers' specific eligibility group that you marked on the application according to Step 3 of this training, select the coverage type for each recipient.

Then, list the start date (the date of the application) and the end date (as listed on the *Notice of Approval*).

Finally, date and sign the *Proof of Temporary Coverage* letter.

Make a copy of the completed letter and provide the copy to the customer. Inform the customer that they must always keep this letter and their *Notice of Approval* with them while receiving care.

Finishing the Presumptive Eligibility Medicaid Process

Keep all customer documents for the hospital's records. Supply copies of these documents to the customer and to DHW. This should include:

- Completed and signed application for *Presumptive Eligibility Medicaid*
- *Notice of Approval or Notice of Denial*
- *Proof of Temporary Coverage* letter, if eligible
- Copy of customers' immigration document, if applicable
- Copy of any income verification documents provided by the customer

Submitting the application to DHW

To submit the application to DHW, call us at 1-855-289-1427, select the Presumptive Eligibility Providers option, within the next business day.

DHW operating hours are Monday – Friday, 8:00 am – 5:00 pm (MST).

Do not mail, fax, or email the application for Presumptive Eligibility Medicaid to DHW until you are asked to do so by the DHW specialist.