Presumptive Medicaid Eligibility Provider's Information Sheet

Rev 1/23/2014

Complete this form if the person needing Medicaid meets one of the following criteria:

- Pregnant woman
- Child under 19 years old
- Adult who has a related child (under 19) living with them

To enroll this customer in Medicaid, call the Department of Health and Welfare directly. Keep a copy of this form for your records.

- **Phone:** 1-855-289-1427

Note: All red fields on this form are mandatory to receive presumptive eligibility, however, all other fields are mandatory for full Medicaid coverage. Type NA (Not Applicable) in the field if it does not apply to you.

Primary Person's Information

First Name	Middle Name	Last Name	Suffix	Date of birth	Former Names, if any

Physical Address	City	State	Zip Code	County

Mailing Address (if different)	City	State	Zip code	County

Daytime Phone	Phone Type	If none, where can we leave a message?	Email
	◯ Work ◯ Home ◯ Cell	Phone:	

Preferred language spoken: | Preferred language written/read:

Social Security Number	Sex	Marital Status	Pregnant?	If yes, due date	How many due?
	◯ M ◯ F	◯ Married ◯ Not Married	◯ No ◯ Yes		

Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

Hispanic or Latino? (Optional) ◯ No ◯ Yes | U.S. citizen or national? ◯ No ◯ Yes

If not a U.S. citizen or national, does this person have eligible immigration status? ◯ No ◯ Yes ◯ N/A

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the U.S. since 1996? ◯ No ◯ Yes ◯ N/A d. A veteran or active-duty member of the U.S. military? ◯ No ◯ Yes

Does the person plan to file a federal tax return for the CURRENT YEAR? ◯ No ◯ Yes

a. Primary tax filer? ◯ No ◯ Yes

b. Filing jointly with a spouse? ◯ No ◯ Yes If yes, name of spouse: _____

c. Claiming dependents? ◯ No ◯ Yes If yes, names of dependents: _____

d. Claimed as a dependent by a: ◯ household member ◯ non-household member Who will be the primary filer? _____

Tell us about the primary person's income

We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

Source of income / Employer name	Employer phone #	Hours per week	$ per hour	How often paid	Total monthly amount	Expected to change? (raise, hours changed, etc.)
						◯ No ◯ Yes If yes, why?
						◯ No ◯ Yes If yes, why?
						◯ No ◯ Yes If yes, why?

Tell us about the primary person's health insurance

Existing health insurance: ◯ None available ◯ Have insurance (complete the fields below)

Health insurance company	Phone number	Policy holder	Policy number	Start date

Tell us about everyone else in the household

Person 1

First Name	Middle Name	Last Name	Suffix	Former Names, if any	Relationship to primary person

Social Security Number	Date of birth	Sex	Marital Status	Pregnant?	
		◯ Male ◯ Female	◯ Married ◯ Not married	◯ No ◯ Yes	If yes, due date: _____ How many due? _____

U.S. Citizen? ◯ No ◯ Yes Alien ID#	Race	Hispanic or Latino: ◯ No ◯ Yes	Birth Country	Birth State (if born in US)

Does this person plan to file a federal tax return NEXT YEAR? ◯ No ◯ Yes

1. Will this person file jointly with a spouse/partner? ◯ No ◯ Yes If yes, name of spouse/partner: _____

2. Does this person have any dependents? ◯ No ◯ Yes If yes, list name(s) of dependents: _____

3. Is this person claimed as a dependent on someone else's tax return? ◯ No ◯ Yes

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

Tell us about the person's income

Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

Source of income / Employer name	Employer phone #	Hours per week	$ per hour	How often paid	Total monthly amount	Expected to change? (raise, hours changed, etc.)
						◯ No ◯ Yes If yes, why? _____
						◯ No ◯ Yes If yes, why? _____

Tell us about the person's health insurance

Existing health insurance: ◯ None available ◯ Have insurance (complete the fields below)

Health insurance company	Phone number	Policy holder	Policy number	Start date

Person 2 ☐ **Check this box if there is no additional person.**

First Name	Middle Name	Last Name	Suffix	Former Names, if any	Relationship to primary person

Social Security Number	Date of birth	Sex	Marital Status	Pregnant?	
		◯ Male ◯ Female	◯ Married ◯ Not married	◯ No ◯ Yes	If yes, due date: _____ How many due? _____

U.S. Citizen? ◯ No ◯ Yes Alien ID#	Race	Hispanic or Latino: ◯ No ◯ Yes	Birth Country	Birth State (if born in US)

Does this person plan to file a federal tax return NEXT YEAR? ◯ No ◯ Yes

1. Will this person file jointly with a spouse/partner? ◯ No ◯ Yes If yes, name of spouse/partner: _____

2. Does this person have any dependents? ◯ No ◯ Yes If yes, list name(s) of dependents: _____

3. Is this person claimed as a dependent on someone else's tax return? ◯ No ◯ Yes

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

Tell us about the person's income

Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

Source of income / Employer name	Employer phone #	Hours per week	$ per hour	How often paid	Total monthly amount	Expected to change? (raise, hours changed, etc.)
						◯ No ◯ Yes If yes, why? _____
						◯ No ◯ Yes If yes, why? _____

Tell us about the person's health insurance

Existing health insurance: ◯ None available ◯ Have insurance (complete the fields below)

Health insurance company	Phone number	Policy holder	Policy number	Start date