NOTICE OF DECISION ON YOUR PRESUMPTIVE MEDICAID ELIGIBILITY APPLICATION FOR HOME HEALTH OR COMMUNITY HOSPICE CARE SERVICES

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
		OR Agency Conference ______
		Fair Hearing Information and Assistance ______
		Record Access ______
		Legal Assistance Information ______

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This Department has made a decision concerning your Medicaid application for presumptive eligibility dated __________. We are sending this notice to tell you that this Department will:

☐ ACCEPT your presumptive Medicaid eligibility application from __________________ to __________________________ pending verification of information in your application.

Please note that Medicaid does not cover hospital-based clinic services, hospital emergency room services, acute hospital inpatient services (except when provided as part of hospice care), and bedhold during the presumptive eligibility period.

Your total unverified monthly income is $__________. The difference between your net income and the Medicaid level is $__________. This is called your monthly surplus income. Each month, Medicaid will pay medical expenses above this figure that are incurred during the month. This figure will be adjusted as necessary to the extent that your verified income is higher or lower than you have indicated.

In addition to any income contribution, $__________ of excess resources must be contributed toward the cost of care from ___________ to _______________.

If, upon full determination of eligibility, it is established that you are not eligible for Medicaid, any medical bills paid on your behalf will be subject to recovery action by the agency. In addition, the provider may seek reimbursement for that portion of the bill not paid by Medicaid.

☐ DENY your application for presumptive Medicaid eligibility for home health or hospice care because:

____

We will contact you to schedule an interview with you to determine your eligibility for regular Medicaid coverage.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS