

HEALTH INSURANCE ELIGIBILITY SCREENING WORKSHEET

Family Name: _____

Worksheet ___ of ___

1. Applicants for Health Insurance on this Worksheet (from section B of the application)					
Adult _____ Line #	Pregnant woman _____ line #	Child _____ line #	Child _____ line #	Child _____ line #	Child _____ line #
Adult _____ Line #	19-20 year old _____ line #	Child _____ line #	Child _____ line #	Child _____ line #	Child _____ line #
2. Family Size*(from Section B of the application)					
a. # of applying adults			_____		
b. # of applying/non-applying children under age 21			_____		
c. # of non-applying legally responsible relatives (spouse for applying spouse; parent for applying children)			_____		
TOTAL			_____		
*Count pregnant woman as 2					
3. Monthly Income					
Family's total countable gross monthly income (from Section E of the application)					\$ _____
(Weekly gross x 4.333333; biweekly gross x 2.166666)					
4. Immigration Status (from Section D of the Application)					
a. For pregnant women, skip this part; GO TO #5.					
b. For persons who are citizens or immigrants who checked A or B in Section D, GO TO #5.					
c. For children under 19 who are <u>not</u> citizens and who checked "NONE" in Section D, GO TO #8.					
d. For persons age 19 or over who are <u>not</u> citizens and who checked "NONE" in Section D, GO TO #11. (Ineligible unless require emergency medical treatment)					
5. Medicaid/Child Health Plus A/PCAP Net Monthly Income					
a. <u>DEDUCTIONS</u>					
_____ # of working family members X \$90/month.....= \$ _____					
Childcare costs (actual or \$200, whichever is less)					
_____ # of children under 2 years X \$ _____.....= \$ _____					
Childcare costs (actual or \$175, whichever is less)					
_____ # of children age 2 years and over X \$ _____.....= \$ _____					
Adult Dependent Care costs (actual or \$175, whichever is less).....= \$ _____					
Health Insurance premium*.....= \$ _____					
\$50 from total child support received= \$ _____					
\$5.00 per day per child for informal daycare.....= \$ _____					
Appropriate expenses from roomer/boarder income.....= \$ _____					
\$20 from Social Security Disability payment (single persons and childless couples only).....= \$ _____					
TOTAL DEDUCTIONS = (\$ _____)					
* health insurance is not a deductible item for non-disabled single adults and childless couples, age 21 or over.					
b. <u>MEDICAID MONTHLY INCOME</u> : subtract Total Deductions (#5.a.) from Monthly Income (#3). Enter result:					\$ _____
Children under age 19 and pregnant women, GO TO #7.a.					
Persons age 19 and over, GO TO #6.					

6. Medicaid Resource Screen (persons 19-64 only; not for pregnant women)

The applicant has attested that the value of the family's resources is equal to or less than the Medicaid resource level for the family size.

Parents, 19-20 year olds, and disabled adults: GO TO #7.a.

Non-disabled single adults and childless couples, age 21-64, GO TO #7.b.

The applicant has attested that the value of the family's resources is greater than the Medicaid resource level for the family size. **GO TO #8**

7.a. Income Screen for CHPlus A / Medicaid / PCAP: Use for parents, persons under age 21, pregnant women, and disabled adults. (Non-disabled single adults and childless couples, age 21-64, go to #7.b.).

Compare the Medicaid Monthly Income (#5.b. \$_____) to the CHPlus A, Medicaid and PCAP Monthly Income Level Chart for the family size (#2.). If the income is equal to, or less than the allowable level, circle "yes." If the income is above the allowable level, circle "no."

Adult, line # ___ Yes/No

Pregnant Woman, line # ___ Yes/No

Adult, line # ___ Yes/No

Person 19-20, line # ___ Yes/No

Child, line # ___ Yes/No

Child, line # ___ Yes/No

Child, line # ___ Yes/No

Child, line # ___ Yes/No

Child, line # ___ Yes/No

Child, line # ___ Yes/No

Child, line # ___ Yes/No

Child, line # ___ Yes/No

**Children under age 19: If "YES," GO TO #11. (eligible for Child Health Plus A)
If "NO," GO TO #8.**

**Pregnant woman: If "YES," GO TO #11. (eligible for PCAP)
If "NO," GO TO #11 (ineligible)**

**Persons age 19 and over: If "YES," GO TO #11 (eligible for Medicaid)
If "NO," GO TO #8.**

7.b. Income Screen for Medicaid: Use for non-disabled single adults and childless couples, age 21-64)

Compare the Medicaid Monthly Income (#5.b.) to the Public Assistance Standard of Need Chart for the family size (#2.). If the income is equal to, or less than the allowable level, circle "yes." If the income is above the allowable level, circle "no."

Adult, line # ___ Yes/No

Adult, line # ___ Yes/No

If "YES," GO TO #11 (eligible for Medicaid)

If "NO," GO TO #8.

8. Equivalent Health Insurance (Section C of the Application)

Do any of the persons applying for Family Health Plus or Child Health Plus B have equivalent health insurance?

**Children under age 19: If "YES," GO TO #11. (ineligible)
If "NO," GO TO #9.**

**Persons age 19 and over: If "YES," GO TO #11 (ineligible)
If "NO," GO TO #10.**

