| Patient | Record | # |
|---------|--------|---|
|---------|--------|---|

| Eligible | |
|----------|--|
|----------|--|

Ineligible

Date care initiated

N.C. Department of Health and Human Services Division of Medical Assistance

| PRESUMPTIVE | FLIGIBILITY | ' DETERMINA' | TION BY | HOSPITAL |
|-------------|-------------|--------------|---------|------------------|
| | LEIGIDIEITI | | | HODI HIML |

| 1 | | | | | | | | | | _ | | |
|-----------------------------|--------------------------------------|------------------------------|--|-------|-----------|--|--|--|--|---|--|---|
| Physica | l Address | | City | | Stat | te | Zip Code | Co | ounty | | | |
| 2. | | | | | | | | | | | | |
| | g Address (if o | lifferent) | City | | Stat | te | Zip Code | Co | ounty | - | | |
| 3. | | | | | | | | 4. | | | | |
| | e Phone | If no | one, where c | an we | eleav | e a message | ? | | Mail | - | | |
| Name (First, M.I., Last) | Date of Birth (mm/dd/ yyyy) | Relationship to applicant | Are you the parent or caretaker relative of a child under age 18? | Sex | Ethnicity | Social Security Number (Not req'd for non- applicant) | U.S. Citizen, U.S National or eligible immigration? (Not req'd for non- applicant) | Will this person file federal income taxes for the current year? | If tax dependent, who will claim them? | Does the tax dependent meet any exceptions? | Does applicant claim anyone not living in the home as a tax dependent? If so, who? | Are you being treated for breast and/or cervical cancer? |
| | | SELF | | | | | | | | | | |
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6. Medicaid Household Composition – Document in section 7 below all members of the applicant's Medicaid household. NOTE: Use MAGI Household Composition Chart

| Name (First, M.I., Last) | Income Type | Amount | Frequency | Gross Monthly Income | Calculation space |
|--------------------------|-------------|--------|------------------------------|-------------------------|-------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | Total Gross Inco | me: | |
| | | | No. in Family Siz | ze: | |
| | | | Family Size Income Limit: | | |

7. Household Income – Document gross income of all individuals determined to be in applicant's Medicaid Household

I understand that this is a temporary determination of my eligibility for Medicaid and that if I do not file an official application for Medicaid by the last day of the month following the month this form is signed my eligibility will stop on that date. I also attest that I have provided true and accurate information about my household and income.

Date

Signature

Provider Name/NPI#

Completed by (print)

Title

Signature/Date

INSTRUCTIONS FOR PROVIDER

I. General

A. Use black ink.

- B. Complete 3 copies
- C. Mail or deliver to the County DSS of the applicant's county of residence no later than 5 working days after the presumptive determination.

II. Patient information

- A. Give the patients current mailing address.
- B. Indicate the name of the county to which the DSS referral will be sent
- C. Document whether patient was determined eligible or ineligible for presumptive.

III. Household – refer to Administrative Letter 18-13 for instructions on how to determine family size.

- A. Enter family members names in the following order:
 - 1. Patient
 - 2. Patient's spouse, if married
 - 3. Other household members
- B. Enter birth date for household members.
- C. Enter household member's relationship to the patient.
- D. Enter sex code for each member.
- E. Enter Social Security number for patient. Optional for other household members.
- F. Indicate if patient is a resident of North Carolina.
- G. Indicate if patient attest to: U.S. Citizenship, U.S. National or eligible immigration.

Eligible Immigration:

| Lawful Permanent Resident (LPR/Green Card holder) | Asylee |
|---|---|
| Refugee | Cuban/Haitian Entrant |
| Paroled into the U.S. | Conditional Entrant Granted before 1980 |
| Battered Spouse, Child and Parent | Victim of Trafficking and his/her spouse, child, sibling or parent |
| Temporary Protected Status (TPS) | Deferred Enforced Departure (DED) |
| Lawful Temporary Resident | Resident of American Samoa |
| Individual with Non-immigration status (includes worker vis | as, student visas, and citizens of Micronesia, the Marshall Islands, and Palau) |
| Granted withholding of Deportation/Removal, under the im | migration Convention against Torture (CAT) |
| Deferred Action Status | |