SD - Submission Package - SD2023MS0004O - (SD-23-0018) - Eligibility

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | SD2023MS0004O | SD-23-0018

Package Header

Package ID SD2023MS0004O
SPA ID SD-23-0018
Submission Type Official
Initial Submission Date 9/11/2023
Approval Date 11/30/2023
Effective Date 8/1/2023
Superseded SPA ID New
User-Entered

The state provides Medicaid services to individuals during a presumptive eligibility period following a determination by a qualified entity.

Presumptive eligibility covered in the state plan includes:

Eligibility Groups

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility for Children under Age 19	☐	☐	○	NEW
Parents and Other Caretaker Relatives - Presumptive Eligibility	☐	☐	○	NEW
Presumptive Eligibility for Pregnant Women	☐	☐	○	NEW
Adult Group - Presumptive Eligibility	☐	☐	○	NEW
Individuals above 133% FPL under Age 65 - Presumptive Eligibility	☐	☐	○	NEW
Individuals Eligible for Family Planning Services - Presumptive Eligibility	☐	☐	○	NEW
Former Foster Care Children - Presumptive Eligibility	☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer - Presumptive Eligibility	☐	☐	○	NEW

Hospitals

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility by Hospitals	☑	☑	○	APPROVED

Presumptive Eligibility

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Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility by Hospitals

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Superseded SPA ID	SD-14-002		
	System-Derived		

☑ The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A. Qualifications of Hospitals

A qualified hospital is a hospital that:

1. Participates as a provider under the state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

3. Assists individuals in completing and submitting the full application and understanding any documentation requirements.

◉ Yes ○ No

Presumptive Eligibility by Hospitals

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	System-Derived		

B. Eligibility Groups or Populations Included

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

○ Yes ◉ No

☐ 9. Other Medicaid state plan eligibility groups:

☐ 10. Demonstration populations covered under section 1115

Presumptive Eligibility by Hospitals

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	System-Derived		

C. Standards for Participating Hospitals

The state establishes reasonable standards for qualified hospitals making presumptive eligibility determinations.

(•) Yes ( ) No

[ ] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

[x] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Percentage of individuals found eligible for Medicaid

90.00%

[ ] The state has elected one or more other reasonable standard(s).

D. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
   - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
   - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. Periods of presumptive eligibility are limited as follows:

( ) a. No more than one period within a calendar year.

(•) b. No more than one period within two calendar years.

( ) c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.

( ) d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) e. Other reasonable limitation:

Presumptive Eligibility by Hospitals

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E. Application for Presumptive Eligibility

☑ 1. The state uses a standardized screening process for determining presumptive eligibility.

☑ 2. The state uses the single streamlined paper and/or online application form for Medicaid and Presumptive Eligibility, approved by CMS. A copy of the single streamlined paper and/or online application with questions necessary for a PE determination highlighted or denoted is included.

☑ a. Paper - A copy of the application form is included.

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☐ b. Online - A copy of the application form is included.

☐ 3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

☐ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

5. Describe the presumptive eligibility screening process:

The Hospital Presumptive Eligibility Program allows qualified hospitals to screen individuals for temporary medical assistance coverage while their full Medicaid application is processed. Hospitals must submit an application to become a qualified hospital. Qualified hospitals are required to verify if an applicant is currently enrolled in Medicaid before providing services to the applicant. Applicants enrolled in Medicaid should not complete an application or have a presumptive eligibility screening. Babies born to mothers enrolled in Medicaid are eligible for the Automatic Newborn Medicaid program and do not require a presumptive eligibility determination.

Individuals may have one (1) presumptive eligibility period every two (2) calendar years or for pregnant women, once per pregnancy. If an applicant has a presumptive eligibility period within the previous two (2) calendar years, the applicant should be informed on how to complete a full Medicaid application. Qualified hospitals will use the Hospital Presumptive Eligibility Application for individuals eligible for screening. Qualified hospitals must gather enough information to complete the Presumptive Eligibility Worksheet in Appendix 1 of the Presumptive Eligibility Training Guide. Either the Notice of Eligibility from Appendix 3 or the Notice of Denial from Appendix 4 must be sent to the applicant based on whether they meet all of the general eligibility criteria, including the income criteria for a coverage group in Appendix 2.

Qualified hospitals must notify the Division of Economic Assistance of presumptive eligibility determination approvals by submitting the following items no later than two (2) working days following the determination: 1) Presumptive Eligibility Medicaid Application; 2) Presumptive Eligibility Worksheet; and 3) Notice to Applicant. Applicants denied coverage through the presumptive eligibility process have the option to have their application sent to the Department of Social Services for a Medicaid determination. This application, along with the notice to the applicant, must be forwarded to the Department of Social Services, Division of Economic Assistance within two (2) working days.

The eligibility period for individuals found eligible through the presumptive eligibility process ends on either the date the eligibility determination is made by the Department of Social Services, if a complete application is filed by the last day of the month following the month in which the presumptive eligibility determine was made, or the last day of the month following the month in which the presumptive eligibility determination was made.

F. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

1. The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

2. Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

○ a. A reasonable estimate of MAGI-based income is used to determine household income.

◉ b. Gross income is used to determine household size.

○ c. Other income methodology

☑ 3. State residency

☑ 4. Citizenship, status as a national, or satisfactory immigration status

Presumptive Eligibility by Hospitals

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G. Qualified Entity Requirements

☑ 1. The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.

2. A copy of the training materials has been uploaded for review during the submission process.

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H. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Hospital Presumptive Eligibility Application

Case #: _____ Section: ___1___

STEP 1: Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name**	Middle name	Last name**	Suffix

2. Home address** *(Leave blank if you don't have one.)*	3. Apartment or suite number**

4. City**	5. State**	6. ZIP code	7. County

8. Mailing address** *(if different from home address)*	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County, parish, or township

14. Home phone number	15. Cell phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ..... ◯ Yes ◯ No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

18. Are there any other people living in your home?..... ◯ Yes ◯ No

STEP 2: Tell us about your family.

Who do you need to include on this application?

Complete the Step 2 pages for every person in your family and household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

For adults who need coverage:

*Include these people **even if they aren't applying for health coverage themselves**:*

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:

*Include these people **even if they aren't applying for health coverage themselves**:*

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

Complete Step 2 for each person in your family.

Start with yourself, then add other adults and children. If you have more than 6 people in your family, you'll need to make a copy of the pages and attach them.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself.)

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name**	Middle name	Last name**	Suffix

2. Relationship to PERSON 1?**	3. Are you married?	4. Date of Birth (mm/dd/yyyy)**	5. Sex
SELF	◯ Yes ◯ No		

6. Social Security Number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check eligibility for coverage and, if you apply, for help with coverage costs. For help getting an SSN, call Social Security at 1-800-772-1213, or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal tax return*

◯ **Yes**. **If yes**, please answer questions a – c. ◯ **No. If no,** skip to question c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No

If yes, write the name of spouse:

b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No

If yes, please list the name of the tax filer:

How are you related to the tax filer?

8. Are you pregnant?** ◯ Yes ◯ No	If yes, how many babies are expected?**	Due date:

9. Do you need health coverage? *Even if you have health coverage, there might be a program with better coverage or lower costs**.*

◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ..... ◯ **Yes.** If yes, complete Appendix F ◯ **No**

11. Are you a **U.S. citizen** or **U.S. National**?** ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a. and b. ◯ **NO. If no,** continue to question 13.

a. Alien number:

b. Certificate Number:

After you complete a and b, skip to question 14

13. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ YES. Enter document type and ID number.

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document

Alien or I-94 Number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

14. Do you want help paying medical bills from the last 3 months? ..... ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?** (select "yes" if you or your spouse takes care of this child) ..... ◯ Yes ◯ No

16. Are you a full-time student? ..... ◯ Yes ◯ No	17.Were you in foster care at age 18 or older?** ..... ◯ Yes ◯ No

Optional: (Fill in all that apply).

18. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano ◯ Puerto Rican ◯ Cuban ◯ Other

19. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other

STEP 2: PERSON 1 (Continue with yourself.)

Current job & income information

◯ **Employed:** if you're currently employed, tell us about your income. Start with question 20.

◯ **Not employed:** Skip to question 30.

◯ **Self-employed:** Skip to question 29

Current job 1:

20. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	21. Employer phone number

22. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper)

24. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	25. Employer phone number

26. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked each WEEK

28. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. **If self-employed, answer a and b:****

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from self-employment this month?

30. Other income you get this month: Fill in all that apply, and give the amount and how often you get it.**

◯ Unemployment	$	How often?	◯ Alimony received	$	How often?
◯ Pension	$	How often?	◯ Net farming/fishing	$	How often?
◯ Social Security	$	How often?	◯ Net rental/royalty	$	How often?
◯ Retirement Accounts	$	How often?	◯ Other income	$	How often?
			Type:		

31. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 29b)

◯ Alimony Paid	$	How often?	◯ Other deduction	$	How often?
◯ Student Loan Interest	$	How often?	Type:		

32. Complete this question if your income changes during the year, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it will be different)

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name**	Middle name	Last name**	Suffix

2. Relationship to PERSON 1?**	3. Are you married?	4. Date of Birth (mm/dd/yyyy)**	5. Sex
	◯ Yes ◯ No		

6. Social Security Number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐ **We need this if you want health coverage for PERSON 2, and PERSON 2 has an SSN**

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal tax return.*

◯ **Yes. If yes**, please answer questions a – c. ◯ **No. If no,** skip to question c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No

If yes, write the name of spouse:

b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No

If yes, please list the name of the tax filer:

How are you related to the tax filer?

8. Are you pregnant?** ◯ Yes ◯ No	If yes, how many babies are expected?**	Due date:

9. Do you need health coverage? ***Even if you have health coverage, there might be a program with better coverage or lower costs.*

◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 7. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ..... ◯ **Yes.** If yes, complete Appendix F ◯ **No**

11. Are you a **U.S. citizen** or **U.S. National**?** ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a. and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: b. Certificate Number:

After you complete a and b, skip to question 14

13. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ YES. Enter document type and ID number.

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document

Alien or I-94 Number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

14. Do you want help paying medical bills from the last 3 months? ..... ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?** (select "yes" if you or your spouse takes care of this child) ..... ◯ Yes ◯ No

16. Are you a full-time student? ..... ◯ Yes ◯ No	17.Were you in foster care at age 18 or older?** ..... ◯ Yes ◯ No

Optional: (Fill in all that apply).

18. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano ◯ Puerto Rican ◯ Cuban ◯ Other

19. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other

STEP 2: PERSON 2

Current job & income information

◯ **Employed:** if you're currently employed, tell us about your income. Start with question 20.

◯ **Not employed:** Skip to question 30.

◯ **Self-employed:** Skip to question 29

Current job 1:

20. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	21. Employer phone number

22. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper)

24. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	25. Employer phone number

26. Wages/tips (before taxes**) ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked each WEEK

28. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. **If self-employed, answer a and b**:**

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from self-employment this month?

30. Other income you get this month: Fill in all that apply, and give the amount and how often you get it.**

◯ Unemployment $	How often?	◯ Alimony received $	How often?
◯ Pension $	How often?	◯ Net farming/fishing $	How often?
◯ Social Security $	How often?	◯ Net rental/royalty $	How often?
◯ Retirement Accounts $	How often?	◯ Other income $	How often?
		Type:	

31. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 29b)

◯ Alimony Paid $	How often?	◯ Other deduction $	How often?
◯ Student Loan Interest $	How often?	Type:	

32. Complete this question if your income changes during the year, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it will be different)

STEP 2: PERSON 3

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name**	Middle name	Last name**	Suffix

2. Relationship to PERSON 1**	3. Are you married?	4. Date of Birth (mm/dd/yyyy)**	5. Sex
	◯ Yes ◯ No		

6. Social Security Number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐ **We need this if you want health coverage for PERSON 3, and PERSON 3 has an SSN**

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal tax return.*

◯ **Yes. If yes**, please answer questions a – c. ◯ **No. If no,** skip to question c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No

If yes, write the name of spouse:

b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No

If yes, please list the name of the tax filer:

How are you related to the tax filer?

8. Are you pregnant?** ◯ Yes ◯ No	If yes, how many babies are expected?**	Due date:

9. Do you need health coverage? *Even if you have health coverage, there might be a program with better coverage or lower costs.*

◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 9. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ..... ◯ **Yes.** If yes, complete Appendix F ◯ **No**

11. Are you a **U.S. citizen** or **U.S. National**?** ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a. and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: b. Certificate Number:

After you complete a and b, skip to question 14

13. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ YES. Enter document type and ID number.

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document

Alien or I-94 Number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

14. Do you want help paying medical bills from the last 3 months? ..... ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?** (select "yes" if you or your spouse takes care of this child) ..... ◯ Yes ◯ No

16. Are you a full-time student? ..... ◯ Yes ◯ No	17.Were you in foster care at age 18 or older?** ..... ◯ Yes ◯ No

Optional: (Fill in all that apply).

18. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano ◯ Puerto Rican ◯ Cuban ◯ Other

19. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other

STEP 2: PERSON 3

Current job & income information

◯ **Employed:** if you're currently employed, tell us about your income. Start with question 20.

◯ **Not employed:** Skip to question 30.

◯ **Self-employed:** Skip to question 29

Current job 1:

20. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	21. Employer phone number

22. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper)

24. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	25. Employer phone number

26. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked each WEEK

28. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. **If self-employed, answer a and b:****

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from self-employment this month?

30. Other income you get this month: Fill in all that apply, and give the amount and how often you get it.**

◯ Unemployment	$	How often?	◯ Alimony received	$	How often?
◯ Pension	$	How often?	◯ Net farming/fishing	$	How often?
◯ Social Security	$	How often?	◯ Net rental/royalty	$	How often?
◯ Retirement Accounts	$	How often?	◯ Other income	$	How often?
			Type:		

31. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 29b)

◯ Alimony Paid	$	How often?	◯ Other deduction	$	How often?
◯ Student Loan Interest	$	How often?	Type:		

32. Complete this question if your income changes during the year, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it will be different)

STEP 2: PERSON 4

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name**	Middle name	Last name**	Suffix

2. Relationship to PERSON 1?**	3. Are you married?	4. Date of Birth (mm/dd/yyyy)**	5. Sex
	◯ Yes ◯ No		

6. Social Security Number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐ **We need this if you want health coverage for PERSON 4, and PERSON 4 has an SSN**

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal tax return*

◯ **Yes. If yes**, please answer questions a – c. ◯ **No. If no,** skip to question c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No

If yes, write the name of spouse:

b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No

If yes, please list the name of the tax filer:

How are you related to the tax filer?

8. Are you pregnant?** ◯ Yes ◯ No	If yes, how many babies are expected?**	Due date:

9. Do you need health coverage? *Even if you have health coverage, there might be a program with better coverage or lower costs.***

◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 11. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ..... ◯ **Yes.** If yes, complete Appendix F ◯ **No**

11. Are you a **U.S. citizen** or **U.S. National**?** ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a. and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: b. Certificate Number:

After you complete a and b, skip to question 14

13. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ YES. Enter document type and ID number.

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document

Alien or I-94 Number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

14. Do you want help paying medical bills from the last 3 months? ..... ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?** (select "yes" if you or your spouse takes care of this child) ..... ◯ Yes ◯ No

16. Are you a full-time student? ..... ◯ Yes ◯ No	17.Were you in foster care at age 18 or older?** ..... ◯ Yes ◯ No

Optional: (Fill in all that apply).

18. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano ◯ Puerto Rican ◯ Cuban ◯ Other

19. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other

STEP 2: PERSON 4

Current job & income information

◯ **Employed:** if you're currently employed, tell us about your income. Start with question 20.

◯ **Not employed:** Skip to question 30.

◯ **Self-employed:** Skip to question 29

Current job 1:

20. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	21. Employer phone number

22. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper)

24. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	25. Employer phone number

26. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked each WEEK

28. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. **If self-employed, answer a and b****

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from self-employment this month?

30. Other income you get this month: Fill in all that apply, and give the amount and how often you get it.**

◯ Unemployment	$	How often?	◯ Alimony received	$	How often?
◯ Pension	$	How often?	◯ Net farming/fishing	$	How often?
◯ Social Security	$	How often?	◯ Net rental/royalty	$	How often?
◯ Retirement Accounts	$	How often?	◯ Other income	$	How often?
			Type:		

31. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 29b)

◯ Alimony Paid	$	How often?	◯ Other deduction	$	How often?
◯ Student Loan Interest	$	How often?	Type:		

32. Complete this question if your income changes during the year, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it will be different)

STEP 2: PERSON 5

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name**	Middle name	Last name**	Suffix

2. Relationship to PERSON 1?**	3. Are you married?	4. Date of Birth (mm/dd/yyyy)**	5. Sex
	◯ Yes ◯ No		

6. Social Security Number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐ **We need this if you want health coverage for PERSON 5, and PERSON 5 has an SSN**

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal tax return.*

◯ **Yes. If yes**, please answer questions a – c. ◯ **No. If no,** skip to question c.

a. Will you file jointly with a spouse? …… ◯ Yes ◯ No

If yes, write the name of spouse:

b. Will you claim any dependents on your tax return? …… ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? …… ◯ Yes ◯ No

If yes, please list the name of the tax filer:

How are you related to the tax filer?

8. Are you pregnant?** ◯ Yes ◯ No	If yes, how many babies are expected?**	Due date:

9. Do you need health coverage? *Even if you have health coverage, there might be a program with better coverage or lower costs.***

◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 13. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? …… ◯ **Yes.** If yes, complete Appendix F ◯ **No**

11. Are you a **U.S. citizen** or **U.S. National**?** …… ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a. and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: b. Certificate Number:

After you complete a and b, skip to question 14

13. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ YES. Enter document type and ID number.

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document

Alien or I-94 Number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

14. Do you want help paying medical bills from the last 3 months? ..... ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?** (select "yes" if you or your spouse takes care of this child) …… ◯ Yes ◯ No

16. Are you a full-time student? …… ◯ Yes ◯ No	17.Were you in foster care at age 18 or older?** …… ◯ Yes ◯ No

Optional: (Fill in all that apply).

18. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano ◯ Puerto Rican ◯ Cuban ◯ Other

19. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other

STEP 2: PERSON 5

Current job & income information

◯ **Employed:** if you're currently employed, tell us about your income. Start with question 20.

◯ **Not employed:** Skip to question 30.

◯ **Self-employed:** Skip to question 29

Current job 1:

20. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	21. Employer phone number

22. Wages/tips (before taxes**) ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper)

24. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	25. Employer phone number

26. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked each WEEK

28. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. **If self-employed, answer a and b:****

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from self-employment this month?

30. Other income you get this month: Fill in all that apply, and give the amount and how often you get it**.

◯ Unemployment $	How often?	◯ Alimony received $	How often?
◯ Pension $	How often?	◯ Net farming/fishing $	How often?
◯ Social Security $	How often?	◯ Net rental/royalty $	How often?
◯ Retirement Accounts $	How often?	◯ Other income $	How often?
		Type:	

31. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 29b)

◯ Alimony Paid $	How often?	◯ Other deduction $	How often?
◯ Student Loan Interest $	How often?	Type:	

32. Complete this question if your income changes during the year, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it will be different)

STEP 2: PERSON 6

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name**	Middle name	Last name**	Suffix

2. Relationship to PERSON 1?**	3. Are you married?	4. Date of Birth (mm/dd/yyyy)**	5. Sex
	◯ Yes ◯ No		

6. Social Security Number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐ **We need this if you want health coverage for PERSON 6, and PERSON 6 has an SSN**

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal tax return*

◯ **Yes. If yes**, please answer questions a – c. ◯ **No. If no,** skip to question c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No

If yes, write the name of spouse:

b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No

If yes, please list the name of the tax filer:

How are you related to the tax filer?

8. Are you pregnant?** ◯ Yes ◯ No	If yes, how many babies are expected?**	Due date:

9. Do you need health coverage? *Even if you have health coverage, there might be a program with better coverage or lower costs.***

◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 15. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ..... ◯ **Yes.** If yes, complete Appendix F ◯ **No**

11. Are you a **U.S. citizen** or **U.S. National**?** ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a. and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: b. Certificate Number:

After you complete a and b, skip to question 14

13. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ YES. Enter document type and ID number.

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document

Alien or I-94 Number	Card number or passport number

SEVIS ID or expiration date (optional)	Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

14. Do you want help paying medical bills from the last 3 months? ..... ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?** (select "yes" if you or your spouse takes care of this child) ..... ◯ Yes ◯ No

16. Are you a full-time student? ..... ◯ Yes ◯ No	17.Were you in foster care at age 18 or older?** ..... ◯ Yes ◯ No

Optional: (Fill in all that apply).

18. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano ◯ Puerto Rican ◯ Cuban ◯ Other

19. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other

STEP 2: PERSON 6

Current job & income information

◯ **Employed:** if you're currently employed, tell us about your income. Start with question 20.

◯ **Not employed:** Skip to question 30.

◯ **Self-employed:** Skip to question 29

Current job 1:

20. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	21. Employer phone number

22. Wages/tips (before taxes)** ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper)

24. Employer Name

a. Employer address

b. City	c. State	d. ZIP code	25. Employer phone number

26. Wages/tips (before taxes) ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked each WEEK

28. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. **If self-employed, answer a and b:****

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from self-employment this month?

30. Other income you get this month: Fill in all that apply, and give the amount and how often you get it.**

◯ Unemployment $	How often?	◯ Alimony received $	How often?
◯ Pension $	How often?	◯ Net farming/fishing $	How often?
◯ Social Security $	How often?	◯ Net rental/royalty $	How often?
◯ Retirement Accounts $	How often?	◯ Other income $	How often?
		Type:	

31. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 329b)

◯ Alimony Paid $	How often?	◯ Other deduction $	How often?
◯ Student Loan Interest $	How often?	Type:	

32. Complete this question if your income changes during the year, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it will be different)

STEP 3: American Indian or Alaska Native (AI/AN) Family Member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

◯ **NO**. **If no**, continue to Step 4 ◯ **YES**. **If yes**, continue to Step 4, plus complete Appendix B and include it with application

STEP 4: Your Family's Health Coverage

1. Is anyone listed on the application offered health coverage from a job?
Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.

◯ **YES.** Continue and then complete Appendix A. **Is this a state employee benefit plan?**.....◯ Yes ◯ No

◯ **NO.**

2. Is the individual applying for Hospital Presumptive Eligibility enrolled in Medicaid, CHIP, or Medicare coverage now?**

◯ **YES.** If yes, continue to question 3.

◯ **NO.** If no, SKIP to Step 5.

3. Check the type of coverage the individual applying for Hospital Presumptive Eligibility has now:**

◯ Medicaid ◯ CHIP ◯ Medicare

STEP 5: Your Agreement & Signature

1. Do you agree to allow the Marketplace to use income data,

including information from tax returns, for the next 5 years? ..... ◯ **YES** ◯ **NO**

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow the Marketplace to use updated income data, including information from tax returns. The Marketplace will send a notice and let you make any changes. The Marketplace will check to make sure you're still eligible and may have to ask you to prove that your income still qualifies. You can opt out at any time.

If no, automatically update my information for the next:

◯ 4 years ◯ 2 years ◯ Don't use my tax data to renew my eligibility for help paying for health coverage

◯ 3 years ◯ 1 years (*selecting this option may impact your ability to get help paying for coverage at renewal.)*

2. Is anyone applying for health insurance on this application incarcerated (detained or jailed)? ..... ◯ **YES** ◯ **NO**

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

If anyone on this application is eligible for Medicaid:

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside the home? ..... ◯ **YES** ◯ **NO**
- If yes, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

- I give my consent for any person, agency, or institution to supply information to the Department of Social Services, about me or my family, and to allow inspection and copying of records about me or my family by any representative of the Department. I release any person, agency, or institution from any liability to me or my family for supplying such information. This consent is given only for use by the Department in administration of its benefit programs.
- As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission or access to, or treatment or employment in, its programs, activities, or services, whether carried out by the Department of Social Services directly or through a contractor or any other entity with which the Department of Social Services arranges to carry out its programs and activities; or on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in, its programs, activities, or services when carried out by the Department of Social Services directly or when carried out by sub-recipients of grants issued by the United States Department of Justice, Office on Violence against Women.
- You may file a complaint by contacting: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501. (605)773-3305. In accordance with state and federal laws, you may also file a complaint with the following agencies: (1) the South Dakota Division of Human Rights (605)773-3681; (2) U.S. Department of Agriculture, Food and Nutrition Services (for discrimination in administering the SNAP (Food Stamp Program) write to Food and Nutrition Services, Mountain Plains Regional Office, Civil Rights Coordinator, 1244 Speer Boulevard, Suite 903, Denver, CO 80204-3585 and the (3) Office of Civil Rights, Jocelyn Samuels, Director, US Department of Health and Human Services, 200 Independence Ave, S.W. Room 509F HHH Bldg, Washington DC 20201.

What should I do if I think my eligibility results are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household, including how many days you have to request an appeal. Below is important information to consider when requesting an appeal:

You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own. If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending. The outcome of an appeal could change the eligibility of other members of your household.

If you wish to appeal our decision to deny or close benefits, you may request a fair hearing by writing any office in the Department of Social Services or send your written request directly to the Office of Administrative Hearings, Kneip Building, 700 Governors Drive, Pierre SD 57501-2291.

I understand that the information on this form is subject to verification by Federal, State, and local officials to determine that such information on this application is correct and complete including citizenship and alien status of the members applying for benefits. If any information is found to be incorrect, benefits may be reduced or terminated, and I will be responsible for paying the benefits back. I declare and affirm under penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct. I understand I may be subject to criminal prosecution for knowingly providing incorrect information. I have read and understand the legal information and understand my responsibilities and agree to fulfill them. I understand the penalties for giving false information or breaking the rules of the assistance program(s).

Signature	Date signed (mm/dd/yyyy)
	/ /

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C.

STEP 6: Mail Completed Application

Mail your signed application to
A local Department of Social Services Office.
A list of offices can be found online at
http://dss.sd.gov/findyourlocaloffice/.

If you want to register to vote, you can complete Appendix E and return it with your application.

Appendix A: Health Coverage from Jobs

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.
Make a copy of this page and take it to the employer who offers coverage to help you answer these questions.

Employee Information

1. Employee name (First, Middle, Last)	2. Employee Social Security Number

Employer Information

3. Employer Name	4. Employer Identification Number (EIN)

5. Employer address			
6. City	7. State	8. ZIP code	9. Employer phone number

10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

◯ YES (Continue) ◯ NO (Stop here and return to Step 5 in the application.)

a. If you're in a waiting or probationary period, when can you enroll in coverage?

☐☐ / ☐☐ / ☐☐☐☐

List the names of anyone else who is eligible for coverage from this job?

Name	Name	Name

Tell us about the lowest-cost health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?..... ◯ YES ◯ NO

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan?

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

16. What change, if any, will the employer make for the new plan year?

◯ Employer won't offer health coverage

◯ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan?

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

c. Date of change: (mm/dd/yyyy)

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986). Most health plans offered by employers meet the minimum value standard.

Appendix B: American Indian or Alaska Native (AI/AN) Household Members

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member is American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	Yes ☐ If yes, tribe name:	Yes If yes, tribe name:
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often?_____	$ _____ How often?_____

AI/AN PERSON 3	AI/AN PERSON 4	AI/AN PERSON 5	AI/AN PERSON 6
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last
Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:	Yes ☐ If yes, tribe name:
☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____	$ _____ How often?_____

Appendix C: Help with Completing this Application

Assistance with Completing this Application

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	
4. ID number (if applicable)	5. Agents/Brokers only: NPN number

You can Choose an Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last Name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
8. Organization name		
9. ID number (if applicable)		

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application

10. Signature of PERSON 1 listed on this application	11. Date signed (mm/dd/yyyy)

Appendix D: Questions About Life Changes

Questions about Life Changes

(You must complete the rest of this application along with this page. Don't submit this page by itself.)

If anyone on this application experienced certain life changes—like losing health coverage, getting married, or having a baby—in the past 60 days (OR expects to in the next 60 days), fill out this page and include it with your completed, signed application. Certain life changes allow your coverage through the Marketplace to start right away. We also recommend you answer these questions if you're applying outside Open Enrollment.

These questions are optional. If your life circumstances haven't changed, you can leave the answers blank. You can enroll in Medicaid and the Children's Health Insurance Program (CHIP) any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Native shareholders can enroll in coverage through the Marketplace any time of the year.

Tell us about changes in your household.

1. Someone lost health coverage in the last 60 days, or expects to lose coverage in the next 60 days.

Names	Date coverage ended or will end (mm/dd/yyyy)
	/ /
○ *Check here if coverage ended because of not paying premiums.*	

2. Someone got married in the last 60 days.

Names	Date (mm/dd/yyyy)
	/ /

3. Someone was born, adopted, or placed for foster care in the last 60 days.

Names	Date (mm/dd/yyyy)
	/ /

4. Someone gained eligible immigration status in the last 60 days.

Names	Date (mm/dd/yyyy)

5. Someone moved in the last 60 days.

Names	Date of move (mm/dd/yyyy)

6. Someone was released from incarceration, detention, or jail in the last 60 days.

Names	Date (mm/dd/yyyy)
	/ /

Appendix E: Voter Registration

Would you like to Register to Vote?

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

◯ **Yes** ◯ **No** **If you are not registered to vote where you live now, would you like to apply to register to vote here today?**

If you do not check either box, you will be considered to have decided NOT to register to vote at this time.

(Failure to check either box is deemed a declination to register for purposes of receiving assistance in registration but is not deemed a written declination to receive an application. If you do not check either box, you will be provided a voter registration form that you may complete at your convenience.)

If you register to vote, the information regarding the office to which the voter registration form was submitted will remain confidential and be used only for voter registration purposes. If you do not register to vote, this decision will remain confidential and be used only for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537.

Appendix F: Additional Questions for Aged, Blind, or Disabled Applicants

Complete this section if you or someone in the household is aged (65 and older), blind, or disabled.
You **DON'T** need to answer these questions unless someone in the household is aged (65 and older), blind or disabled. These questions will help us determine your eligibility for Non-MAGI Medicaid programs and/or Long-term Care.

Person Information

Name of person

Do you know what type of benefit you wish to apply for? If yes, please indicate the type below:

◯ Nursing Facility ◯ Assisted Living ◯ Hospitalization ◯ In-Home Services ◯ Group Home ◯ Family Support Waiver ◯ MAWD
◯ Disabled Children's Program ◯ Other/Unknown

Facilty Information

Do you currently live a facility or expect to live in a facility? …….. ◯ Yes ◯ No

Facility name

Facility address

City	State	ZIP code

Admission Date	Discharge date (if applicable)

Do you plan to return home within six (6) months? *(If yes, provide letter from physician)* …….. ◯ Yes ◯ No

Were you in the hospital prior to moving to a facility or receiving services in your home? …….. ◯ Yes ◯ No

If yes, date you were admitted to the hospital? (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Resource Information

Tell us about all resources for this person and their spouse, including cash, checking and savings accounts, Social Security debit cards, health savings accounts, pensions, stocks, bonds, mutual funds, annuities, safe deposit boxes, 401Ks, IRAs, CDs, etc.

Owner Name(s)	Resource Type	Bank Name	Account Number	Value

Trust Information

Is this person or their spouse named in any trusts or do they have ownership of any trust? …….. ◯ Yes ◯ No

Owner Name(s)	Bank Name	Bank Address	Account Number	Value

Life Insurance Information

Does this person or their spouse have any life insurance policies? ..... ◯ Yes ◯ No

Name of Insured Person (First Name, MI, Last Name)	Name of Policy Owner		
Insurance Company Name	Policy Number		
Address	City	State	Zip

Burial Fund Information

Does this person or their spouse have any bank accounts designated for burial, prepaid burial contracts, trusts, or other financial arrangements for services? ..... ◯ Yes ◯ No

Name of the organization who keeps the funds	Date Purchased (mm/dd/yyyy)	Value
City	State	Zip

Name of the organization who keeps the funds	Date Purchased (mm/dd/yyyy)	Value
City	State	Zip

Vehicle Information

Does this person or their spouse have any cars, trucks, boats, or other recreational vehicles? ..... ◯ Yes ◯ No

Owner Name(s)	Make/Model	Year	Value	Amount Owed

If more than one vehicle is listed above, which do you use as your primary method of transportation?

Property Information

Does this person or their spouse have any property (including a home, mobile home, lots, or land)? ..... ◯ Yes ◯ No

Owner(s)	Property Address	Property Value

Other Information

Does anyone in your household have a life estate? ……..	○ Yes ○ No
If yes, who?	
Has anyone in your household not accepted an inheritance in the past five years? ……...	○ Yes ○ No
If yes, who?	
Has anyone in your household transferred, sold, or given away resources for less than their value in the past five years?……	○ Yes ○ No
If yes, who?	
Does anyone in your household have a pending disability application? ……...	○ Yes ○ No
If yes, who?	
Are you applying for any child(ren) who are under age 19, have a disabling condition **and** their parent or guardian is trained to provide skilled nursing care in the home? ……..…….……....	○ Yes ○ No
If yes, child name(s):	
Does anyone in your household have End-Stage Renal Disease (ERSD)? ……..…….....	○ Yes ○ No
If yes, who?	

To speed up the processing of your application.

Please provide verification (e.g., bank statements, property tax statements, burial contracts, insurance policies, etc.) for any of the above questions with your application. **Send copies of documents. Do not send original documents.** If verification is not submitted with the application, you may receive a letter indicating what we need before we can finish processing your application.

Presumptive Eligibility Training Guide

Hospital Presumptive Eligibility

South Dakota Division of Economic Assistance

November 2023

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PREFACE

Medicaid is a joint federal and state program established in 1965, under Title XIX of the Social Security Act. The purpose of the Medicaid Program is to assure the availability of quality medical care for low-income individuals and families through payments for specific covered services. The Medicaid program was implemented in South Dakota in 1967. The Department of Social Services (DSS) is the single-state agency responsible for administering the Medicaid program in South Dakota. The Division of Medical Services oversees the Medicaid Program. Eligibility determinations for the Medicaid program are performed by the Division of Economic Assistance.

The Hospital Presumptive Eligibility (HPE) Program allows qualified hospitals to make temporary eligibility determinations in accordance with federal law and state policy for the Medicaid program. This guide contains the policies and procedures governing the HPE Program in South Dakota. Questions about this guide may be directed to:

South Dakota Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501
Phone: (605) 773-4678
Fax: (605) 773-7183

The policies and procedures found in this manual are subject to review and amendment by the South Dakota Department of Social Services. Check this manual frequently for updates.

GENERAL INFORMATION

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)

Under 42 CFR §435.1110, a qualified hospital or qualified individual may elect to make HPE determinations based on a State's policies and procedures. HPE is a temporary medical assistance category that allows an individual to receive covered medical services.

A hospital may elect to make HPE determinations for one or more of the following groups:

- Low-Income Families (Parent and Other Caretaker Relatives)
- Medicaid Children Under Age 19
- Pregnant Women
- South Dakota Medicaid for Youth Formerly in Foster Care
- Breast and Cervical Cancer Program (*the hospital must be an All Women Count! Program provider)*
- Medicaid Expansion – Adult Group (Individuals Aged 19 or Older and Under Age 65 At or Below 138% of the Federal Poverty Level)

Hospitals must identify the eligibility groups that the hospital elects to make HPE determinations for on the South Dakota Hospital Presumptive Eligibility Application.

Hospitals may not delegate the authority to determine HPE eligibility to another entity.

COVERED SERVICES

The following services are eligible for reimbursement during an HPE period:

- Low Income Families (Parents and Other Caretaker Relatives), Medicaid Children Under age 19, South Dakota Medicaid for Youth Formerly in Foster Care, Breast and Cervical Cancer Program, and Medicaid Expansion – Adult Group (Individuals Aged 19 or Older and Under Aged 65 At or Below 138% of the Federal Poverty Level) are eligible to receive all Medicaid covered services.

- Pregnant Women are eligible for ambulatory prenatal care. Ambulatory prenatal care includes pregnancy-related Medicaid covered services except charges associated with inpatient care in a hospital or other medical institution and charges associated with delivery of the baby, including miscarriage. A woman is allowed only one presumptive eligibility period per pregnancy.

HPE PERIOD

The HPE period refers to the **duration** of coverage (the length of time HPE lasts, which has a start and end date) and the **frequency** of coverage (how often someone can receive HPE).

Duration
The HPE period begins with the date on which a qualified hospital determines that the individual is eligible.

The HPE period ends when one of the following circumstances happens, whichever is earliest:

- If the individual does not file a Medicaid application with the Department of Social Services, the HPE period ends on the last day of the month following the HPE determination (the "second month"), or
- If the individual does file a full application with the Department of Social Services before the last day of the second month, HPE ends on the date the eligibility determination is made for regular coverage.

Frequency
An individual is allowed one HPE period every two calendar years.

A pregnant woman is allowed one presumptive eligibility period per pregnancy.

QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY APPLICATION

A "qualified hospital" is defined as a hospital that:

1. Participates as a provider under the South Dakota Medicaid State Plan;
2. Notifies the South Dakota Department of Social Services of its election to make presumptive eligibility determinations;
3. Agrees to make presumptive eligibility determinations consistent with South Dakota policies and procedures;
4. Assists individuals in completing and submitting the full application for medical assistance and understanding any documentation requirements; and
5. Has not been disqualified by the Department of Social Services.

Hospitals must submit an application to become a qualified hospital. Providers may contact the Division of Medical Services at (605) 733-3495 to request a South Dakota Hospital Presumptive Eligibility Application.

DISQUALIFICATION OF QUALIFIED HOSPITAL

The State of South Dakota is required to establish standards for qualified hospitals. The qualified hospital must agree to make presumptive eligibility determinations consistent with South Dakota policies and procedures. The State of South Dakota is required to take action,

including, but not limited to, disqualification of a hospital as a qualified hospital if the State determines the hospital is not making, or is not capable of making presumptive eligibility determinations in accordance with applicable South Dakota policies and procedures or meeting the standards established by the Department of Social Services. The hospital may only be disqualified from the HPE Program after the Department of Social Services has provided the hospital with additional training or taken other reasonable corrective measures.

Performance standards and compliance with South Dakota policies will be evaluated on a quarterly basis. Qualified hospitals failing to meet performance standards or adhere to South Dakota policies will be required to submit a corrective action plan to the Department of Social Services that includes remedial training provided by the Department. If the qualified hospital fails to meet minimum performance standards following remedial training and the corrective action plan, the hospital may be disqualified from participation in the HPE program.

Qualified hospitals may withdraw from the HPE program at any time upon written notice to the South Dakota Department of Social Services.

PROGRAM REQUIREMENTS

The State of South Dakota has established the following requirements for qualified hospitals participating in the HPE Program. Qualified hospitals must:

1. Designate an interviewer(s) and notify the South Dakota Department of Social Services of the name, title, and telephone number of all employees conducting presumptive eligibility determinations.

2. Notify the Department when new employees are designated to perform presumptive eligibility determinations.

3. Assure employees authorized to perform presumptive eligibility determinations are not employees with authority or responsibility to submit claims to the Medicaid program for reimbursement of Medicaid services. Assure no presumptive eligibility determination functions will be delegated to non-hospital staff, third party vendors, or contractors.

4. Assure that all designated employees complete presumptive eligibility training provided by the Department of Social Services prior to performing presumptive eligibility determinations. Retain documentation of all training completed on file at the hospital. *Note: HPE training and determinations are not reimbursable. Qualified hospitals are reimbursed for Medicaid covered services provided to individuals determined to be presumptively eligible.*

5. Assure capability of assisting applicants who need the assistance of an interpreter.

6. Provide training to all designated employees on security and privacy laws, regulations, and standards prior to the performing presumptive eligibility determinations. Assure all designated employees sign a statement regarding confidential information obtained during the presumptive eligibility process. Proof of signed confidentiality agreements must be retained on site by the qualified hospital for

a minimum of 3 years.

Any information obtained during the HPE application process is considered confidential and may not be disclosed to any persons or agencies other than representatives of the Department of Social Services and its designees. Information is confidential whether the application is approved or denied and may not be shared with collection agencies or any other third-party.

7. Provide *Notice of Privacy Practices* to the applicant.

8. Verify that the individual is not currently enrolled in Medicaid or CHIP or that the individual has had a prior presumptive eligibility determination in the previous two calendar years. On a monthly basis, the Department will provide qualified hospitals with a list of applicants determined presumptively eligible in the previous two years.

9. Follow procedures found in the *Presumptive Eligibility Training Guide– Hospital Presumptive Eligibility.*

10. Screen applicants using the *Presumptive Eligibility Worksheet* and perform necessary calculations to determine if the applicant meets the criteria for presumptive eligibility.

11. Issue an HPE determination letter on the approved form to the applicant that clearly indicates the outcome of the presumptive eligibility determination. If determined presumptively eligible, explain the next steps the applicant must take to complete the application process, including the end date of presumptive eligibility period and covered Medicaid services during the presumptive eligibility period.

12. Assist applicants in the completion and submission of a full Medicaid application and understanding any documentation requirements.

13. Provide all applicants with contact information for the South Dakota Department of Social Services.

14. If the applicant does not complete a full Medicaid application during the presumptive eligibility interview or at the hospital, provide the applicant with a copy of the application and direct the applicant where to submit the application upon its completion.

15. Forward the completed Presumptive Eligibility Medicaid application, *Presumptive Eligibility Worksheet*, and a copy of the determination letter to the Division of Economic Assistance, ATTN: Presumptive Eligibility within two working days of the presumptive eligibility determination.

16. Have a computer, internet, telephone, printer, and fax access available for applicants to facilitate the presumptive eligibility and full Medicaid application process.

17. Secure all documents in a locked file cabinet not accessible to public or employees not designated as presumptive eligibility employees or who have not signed a confidentiality statement.

18. Communicate with the Department of Social Services to resolve any issues or concerns and to establish efficient policies and procedures to perform presumptive eligibility determinations.

19. Each qualified hospital must maintain records of the hospital's activities related to presumptive eligibility determinations. Records must be retained for a minimum of 6 years as required by Administrative Rule of South Dakota (ARSD) §67:16:34:05.

    Track and report the following data each quarter:

    (1) Number of individuals screened for presumptive eligibility
    (2) Number of individuals approved for presumptive eligibility
    (3) Number of individuals rejected for presumptive eligibility
    (4) Reasons for each presumptive eligibility rejection
    (5) Dates on which individuals are screened, approved, and rejected for presumptive eligibility

20. Maintain at least a 90% accuracy rate when performing HPE Determinations. 90% of all the presumptive eligibility decisions made by the hospital must be the same decision reached by the Department when a full Medicaid eligibility decision is made.

21. Provide written notice to the Department of intent to withdraw from the HPE Program. Written notice may be given at any time.

22. The qualified hospital must monitor the quality of the case processing by reviewing a sample of completed cases. It is recommended that at least one case review per month be completed for each designated employee. If frequent errors are noted, corrective action must be taken.

NON-DISCRIMINATION

Title IV of the Federal Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the groups of race, sex, color, national origin, or handicap in the administration of federally-funded programs. This includes Medicaid and CHIP programs.

TRAINING AND COMMUNICATIONS

The qualified hospital must designate a primary contact for the HPE Program for the Department of Social Services who is responsible for communication to the Department regarding program changes, questions, personnel changes, and other issues.

Qualified hospitals must designate all employees involved in the HPE process. All designated employees must obtain training from the Department of Social Services prior to performing HPE functions. Each employee will be required to certify that they have received training on South Dakota policies and procedures and agree to perform presumptive eligibility determinations in accordance with the requirements outlined by the Department of Social Services. The qualified hospital must retain a copy of employee certifications.

After the Department has approved the hospital's Presumptive Eligibility Application, the Department will work with the primary contact to schedule face-to-face training with designated employees. During the training period, the qualified hospital and the Department of Social Services will make ten joint presumptive eligibility determinations. Joint determinations will not count towards the qualified hospital's Medicaid determination rate. In the event that the qualified hospital requires remedial training, the Department and the qualified hospital will make another ten joint presumptive eligibility determinations.

Additional trainings may be scheduled as the qualified hospital designates new employees for presumptive eligibility determinations.

CLAIMS PROCESSING

Qualified hospitals should delay submitting claims for services provided to individuals determined eligible by the HPE Program for one week from the eligibility start date to ensure the eligibility information is transmitted to the Division of Medical Services and to prevent claims from being inappropriately denied.

Claims must be for a covered Medicaid Service and submitted in accordance with ARSD §67:16. HPE claims should be submitted in the same manner as all other claims submitted by the entity. No special processing is needed.

SCREENING AND APPLICATION ASSISTANCE

STEP 1: MEDICAL ASSISTANCE SCREENING

Qualified hospitals are required to verify if an applicant is currently enrolled in Medicaid before providing services to the applicant.

All providers are encouraged to use the South Dakota Medicaid Provider Portal, Medicaid Eligibility Verification System (MEVS), or the South Dakota Medicaid Interactive Voice Response (IVR) and Telephone Service Unit by calling 1-800-452-7691 to verify eligibility.

If an applicant is enrolled in Medicaid, do not have the applicant complete an application and do not complete an HPE determination.

If a baby is born to a mother enrolled in Medicaid, do not have the mother complete an application and do not complete an HPE determination. The baby will be eligible for the Automatic Newborn program when the birth is reported to the Department of Social Services. The hospital may contact the Division of Economic Assistance to report the birth.

If an applicant is not currently enrolled in Medicaid, assist the applicant in completing an application and determine eligibility for the HPE Program.

STEP 2: PRESUMPTIVE ELIGIBILITY SCREENING

HPE periods are limited to no more than one period within two calendar years per applicant. Pregnant Women are eligible for one HPE period per pregnancy, even if they had an HPE period that occurred less than 24 months prior. Qualified hospitals are required to verify if an applicant has been enrolled in an HPE period within two calendar years of the date of the HPE application. On a monthly basis, the Department will provide qualified hospitals with a list of applicants determined presumptively eligible in the previous two years.

If an applicant has an HPE period within the previous two calendar years, give the applicant information about how to complete a full Medicaid application.

STEP 3: PRESUMPTIVE ELIGIBILITY APPLICATION ASSISTANCE

Qualified hospitals must use the *Presumptive Eligibility Medicaid Application*. This form may be obtained from the Department of Social Services, Division of Economic Assistance, 605-773-4678.

If an individual does not elect to submit a full Medicaid application, *only the questions needed for an HPE determination are required.* **These questions are denoted with an asterisk on the *Presumptive Eligibility Medicaid Application* and only these questions should be asked for an HPE determination. Do not ask other questions if the individual is not submitting a full Medicaid application.**

The answers to these questions will provide enough information to complete the Presumptive Eligibility Worksheet found in Appendix 1.

DETERMINING PRESUMPTIVE ELIGIBILITY

Section 1 – Non-Financial Eligibility

Before starting, ensure the SCREENING AND APPLICATION ASSISTANCE chapter has been reviewed.

Reference the guidance in this section to determine if the boxes in Section 1 of the Presumptive Eligibility Worksheet (Appendix 1) can be checked.

Eligible Population Screening

If an applicant is enrolled in Medicaid, do not have the applicant complete an HPE application and do not complete an HPE determination.

An individual is allowed one HPE period every two calendar years. A pregnant woman is allowed one HPE period per pregnancy. The following examples can assist in determining if an individual is within the allowable timeframes for an HPE period.

Example 1

Dee applies for HPE on April 21, 2023. She did not have an HPE period in the last 24 months. She is determined eligible on April 21, 2023.

HPE Start Date	**HPE End Date:** Dee *does file* a full Medicaid application and is determined eligible on May 5, 2023.	**HPE End Date:** Dee *does not file* a full Medicaid application.
April 21, 2023	May 5, 2023	May 31, 2023

Example 2

Janice applies for HPE on May 1, 2023. She is pregnant. Her last HPE period occurred during her previous pregnancy, with a start date of July 1, 2022.

Is Janice eligible?	**HPE Start Date**	**HPE End Date:** Janice *does file* a full Medicaid application and is determined eligible on May 10, 2023.
Yes. Even though it has been less than a year since her last HPE determination, she is pregnant and pregnant individuals are allowed one HPE period per pregnancy.	May 1, 2023	May 10, 2023

Citizenship/National or Qualified Alien

Immigrants who are “qualified non-citizens” are generally eligible for coverage through Medicaid and the Children’s Health Insurance Program (CHIP) if they meet income and residency rules.

In order to get Medicaid and CHIP coverage, many qualified non-citizens (such as many LPRs or green card holders) have a 5-year waiting period. This means they must wait 5 years after receiving "qualified" immigration status before they can get Medicaid and CHIP coverage. There are exceptions. For example, refugees, asylees, or LPRs who used to be refugees or asylees don't have to wait 5 years.

Without a Five-Year Waiting Period

1. Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants);
2. Lawful Permanent Residents (green-card holders or LPRs who adjusted to LPR from an immigration status that is exempt from the 5-year bar listed at numbers 3-10, below);
3. Refugee admitted to the U.S. under section 207 of the INA;
4. Granted asylum under section 208 of the INA;
5. Withholding of deportation or removal under section 243(h) or 241(b)(3) of the INA;
6. Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980;
7. Amerasian immigrant admitted pursuant to section 584 of Public Law (Pub. L. No.) 100-202 (1211987), as amended by Pub. L. No. 100-461 (10/1988);
8. Applicants for a victim of trafficking/T-visa or victim of trafficking with a certification or eligibility letter from the Office of Refugee Resettlement;
9. Iraqi/Afghan special immigrant visa holder; and
10. Members of a federally recognized Indian tribe or American Indian born in Canada.

With a Five-Year Waiting Period (from the date they received the qualifying status)

11. Lawful Permanent Residents (i.e., green-card holders or LPRs), unless adjusted from a status that is exempt from the 5-year waiting period at 3-10 (above);
12. Battered non-citizens and their children or parents;
13. Non-citizens paroled into the U.S. for at least one year. ***Exception: Afghan and Ukrainian nationals:***
    - **Afghans** who are paroled between July 31, 2021 and September 30, 2023 are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period, if they meet other eligibility requirements (e.g., income) for coverage in the state, until March 31, 2023, or the term of parole granted to the evacuee, whichever is later, and
    - **Ukrainian nationals** who enter the United States as parolees on or between February 24, 2022 and September 30, 2023 are eligible for Medicaid or CHIP to the same extent as refugees).
        - Ukrainian nationals who are paroled into the U.S. after September 30, 2023 and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and CHIP to the same extent as refugees.
        - Eligible parolees can also include individuals other than Ukrainian nationals (i.e., individuals who are stateless or have another nationality) who last habitually resided in Ukraine.

14. Conditional entrants granted status prior to April 1, 1980 (Note: because of the grant date requirement, these non-citizens will already have met the 5-year waiting period);
15. **Exception**: qualified non-citizens (11-15) are exempt from the 5-year waiting period if they are:
    - Veterans who received an honorable discharge, or
    - A military service member on active duty in the armed forces of the United States (other than active duty for training-i.e., Reserves), or
    - A spouse or unmarried dependent child of a veteran or active duty service member as described above, or
    - Have lived in the US since 1996, or
    - An American Indian born in Canada to whom the provisions of 8 U.S.C. 1359 apply, or
    - A member of an Indian tribe, as defined in 25 U.S.C. 450b(e).
16. **Exception**: Non-citizens receiving SSI are eligible for Medicaid without a 5-year waiting period, regardless of immigration status. 435.406(a)(iii)(A).

Residency

In order to be eligible for South Dakota Medicaid, an applicant must be a resident of the State of South Dakota. Applicants can attest to state residency by declaring an intent to remain in South Dakota. Additional verification is not required.

It is **not** a condition of HPE eligibility to have a fixed (residential) address. Applicants should provide an address where they can receive mail. Persons experiencing homelessness, the unhoused, and those with nonpermanent residences may use any mailing address they find convenient, including but not limited to mail forwarding services, local nonprofit mail centers, the address of a friend or family, post office boxes, or USPS General Delivery.

An applicant is not considered a resident if the applicant is in South Dakota for a temporary reason such as a vacation, business trip, or attending a South Dakota college without intent to remain in South Dakota after completion of the course of study.

Section 2 – Applicant Coverage Group

Reference the guidance in this section to accurately determine the coverage group in Section 2 of the Presumptive Eligibility Worksheet (Appendix 1).

For HPE eligibility to exist, the individual must meet the criteria of an HPE coverage group.

Individuals in the following groups may be eligible for an HPE period if they meet the category criteria:

Coverage Group	Eligibility Criteria
Low-Income Families (Parents and Other Caretaker Relatives)	Individuals of any age living with and caring for a related (biological, adopted, or step) child or grandchild, sibling, nephew, niece, or first cousin under age 19 with household income at or below the income threshold.
Medicaid for Children Under Age 19	Children under age 19 with household income up to 187% FPL.
Pregnant Women	Individuals who attest that they are pregnant and have household income at or below the 138% FPL threshold.
South Dakota Medicaid for Youth Formerly in Foster Care	Individuals aged 18 to 26 who were in DOC or CPS custody under the responsibility of any State or Tribe on their 18th birthday and leave foster care. There is no income test.
Breast and Cervical Cancer Program	Individuals aged 30 through 64 who have been found in need of treatment for breast or cervical cancer, are not eligible for Medicare Part B, and attest to income below 200% FPL.
Medicaid Expansion – Adult Group	Adults at least age 19 but less than 65 who are not pregnant, not entitled to or enrolled in Medicare, and who have household income at or below the income threshold of 138% FPL.

If an individual meets the criteria of more than one coverage group, choose the coverage group with the highest income limit or the category that provides the best coverage. For example, a pregnant 18-year-old may meet the criteria of Medicaid for Children Under Age 19 and Pregnant Women. They would gain eligibility through the Medicaid for Children Under Age 19, which provides a higher level of coverage than Pregnant Women.

The following examples are included to assist in determining possible coverage categories for HPE applicants. These examples are not comprehensive.

Example 1:
James (52) and John (54) are married. They have one adult child who lives outside of the home.

Individual	Coverage Group
James	Medicaid Expansion – Adult Group
John	Medicaid Expansion – Adult Group

Example 2:
Annie (28) and Albert (24) are not married. They live with their two children – Alice (5) and Alexis (3).

Individual	Coverage Group
Annie	Low-Income Families (Parents and Other Caretaker Relatives) or Medicaid Expansion – Adult Group
Albert	Low-Income Families (Parents and Other Caretaker Relatives) or Medicaid Expansion – Adult Group
Alice	Medicaid for Children Under Age 19
Alexis	Medicaid for Children Under Age 19

Example 3:
Jordan (39) is pregnant with twins and lives with her boyfriend, Jose (33), and Jose's son, Jamal (17), from a previous relationship.

Individual	Coverage Group
Jordan	Pregnant Women
Jose	Low-Income Families (Parents and Other Caretaker Relatives)
Jamal	Medicaid for Children Under Age 19

Example 4:
Amir (42) and Amiya (45) are married and live with Amiya's children from a previous relationship, Brynn (22) and Breanna (16).

Individual	Household Size
Amir	Low-Income Families (Parents and Other Caretaker Relatives) or Medicaid Expansion – Adult Group
Amiya	Low-Income Families (Parents and Other Caretaker Relatives) or Medicaid Expansion – Adult Group
Brynn	Medicaid Expansion – Adult Group
Breanna	Medicaid for Children Under Age 19

Section 3 – Eligibility Calculation

This section is not required if the applicant is applying for South Dakota Medicaid for Youth Formerly in Foster Care.

For all other coverage groups, reference the guidance in this section to complete the steps in Section 3 of the Presumptive Eligibility Worksheet (Appendix 1).

Step 1 - Household Size

Presumptive eligibility is based on an individuals' income as a percentage of the FPL. To determine a person's percentage of the FPL, the household size must be accurately determined. A household size includes all the individuals in the home who are required to be in it. There are specific family relationships that are tied together, which make certain individuals financially responsible for each other.

The household size determination must be done *for each applicant* requesting a presumptive eligibility determination. Count the following people as part of the applicant's household*:

If the applicant is under age 19, their household includes (if living with):	If the applicant is age 19 or older, their household includes (if living with):
• The individual • The individual's children • If pregnant, the number of unborn children of the individual • The individual's spouse (if married) • Parent(s) – biological, adoptive, and step • Any sibling under the age of 19	• The individual • If pregnant, the number of unborn children of the individual • The individual's spouse (if married) • Children under the age of 19 – biological, adoptive, and step

*Former Foster Care is always a household of one, which includes only the individual.

Examples – How to Determine Household Size

Example 1:
James (52) and John (54) are married. They have one adult child who lives outside of the home.

Individual	Household Size
James	2 – James (self) and John (spouse)
John	2 – John (self) and James (spouse)

Example 2:
Annie (28) and Albert (24) are not married. They live with their two children – Alice (5) and Alexis (3).

Individual	Household Size
Annie	3 – Annie (self), Alice (minor child), and Alexis (minor child)
Albert	3 – Albert (self), Alice (minor child), and Alexis (minor child)
Alice	4 – Alice (self), Annie and Albert (parents), and Alexis (sibling under 19)
Alexis	4 – Alexis (self), Annie and Albert (parents), and Alice (sibling under 19)

Example 3:

Jordan (39) is pregnant with twins and lives with her boyfriend, Jose (33), and Jose's son, Jamal (17), from a previous relationship.

Individual	Household Size
Jordan	3 – Jordan (self) and unborn twins
Jose	2 – Jose (self) and Jamal (minor child)
Jamal	2 – Jamal (self) and Jose (parent)

Example 4:
Amir (42) and Amiya (45) are married and live with Amiya's children from a previous relationship, Brynn (22) and Breanna (16).

Individual	Household Size
Amir	3 – Amir (self), Amiya (spouse), and Breanna (minor stepchild)
Amiya	3 – Amiya (self), Amir (spouse), and Breanna (minor child)
Brynn	1 – Brynn (self)
Breanna	3 – Breanna (self), Amir (stepparent), and Amiya (parent)

After determining household size, enter the number in Step 1 of Section Three on the Presumptive Eligibility Worksheet (Appendix 1).

Step 2 – Income Limit

Reference the Income Limit Chart on the Presumptive Eligibility Worksheet to enter the corresponding income limit for the household size and coverage group in Step 2.

Income limits for coverage groups are based on a percentage of the Federal Poverty Level (FPL), which is the minimum amount of income a person or family needs for necessities. Low Income Families (Parents and Other Caretaker Relatives) is not based on a percentage of FPL, but instead on a converted threshold of the income limits South Dakota Administrative Rule 67:46:12:08.

Each coverage group is subject to different income standards. This means that, depending on each family member's eligibility group, some members of a family may be eligible for HPE while others are not eligible, even though the family members have the same household income and household size.

There is no income limit for South Dakota Medicaid for Youth Formerly in Foster Care.

Coverage Group	FPL
Low-Income Families (Parents and Other Caretaker Relatives)	**N/A (see above)**
Medicaid for Children Under Age 19	**187%**
Pregnant Women	**138%**
South Dakota Medicaid for Youth Formerly in Foster Care	**N/A (see above)**
Breast and Cervical Cancer Program	**200%**
Medicaid Expansion – Adult Group	**138%**

Income guidelines and additional eligibility information is available on the Department's website at https://dss.sd.gov/economicassistance/medical_programs.aspx.

Step 3 – Household Monthly Income

Countable & Non-Countable Income
You must first determine if the income is countable or not countable. Some types of income are not counted when determining eligibility.

Countable Income	Non-Countable Income
• Wages/tips • Net self-employment income • Pensions and annuities • Social Security (Old-Age, Survivors, and Disability Insurance – excluding SSI) • Unemployment	• Federal Veteran's Benefits • Child Support • Worker's Compensation • Scholarships, fellowship grants, and awards used for educational purposes. • Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) • Supplemental Security Income (SSI) • Children's wages when they do not exceed the tax filing threshold

Monthly Income Total – Individual
Income is based on pre-tax income (not take-home pay). If a gross amount is not provided, you may ask about the hourly rate of pay and number of hours worked per week or pay period.

If income is not reported as a monthly amount, you must convert the income to a monthly amount. You will need to know how often the individual is paid, how many hours per week they work, and their hourly rate. Use the following formulas to convert pay to a monthly amount.

If the individual is paid…	Then…
Weekly	Multiply gross pay by 4.3
Bi-weekly	Multiply gross pay by 2.15
Twice a Month	Multiple gross pay by 2
Monthly	No Calculation Needed
Annually	Divide gross pay by 12

Monthly Income Total – Household
Household income is the combined pre-tax income (not take-home pay) of *all included family members.*

To determine the household income, follow these steps:
1. Determine who must be included in the applicant's household (Step 1)
2. Determine whether any of these individuals have countable income (see above)
3. Total the countable income of every individual in the applicant's home.

Example 1:
James (52) and John (54) are married. James earns $300 biweekly at his job and John earns $100 monthly.

Individual	Household Income
James	$745 ($300 x 2.15 = $645, + $100 = $745 monthly)
John	$745 ($300 x 2.15 = $645, + $100 = $745 monthly)

Example 2:
Annie (28) and Albert (24) are not married. They live with their two children – Alice (5) and Alexis (3). Annie receives SSI of $914 a month. Albert earns $1,000 monthly at his job.

Individual	Household Income
Annie	$0 (SSI is not countable and Albert is not in her household as they are not married)
Albert	$1,000 (Annie is not in his household as they are not married)
Alice	$1,000 ($0 for Annie's SSI and $1,000 monthly for Albert's wages)
Alexis	$1,000 ($0 for Annie's SSI and $1,000 monthly for Albert's wages)

Example 3:
Jordan (39) is pregnant with twins and lives with her boyfriend, Jose (33), and Jose's son, Jamal (17), from a previous relationship. Jordan receives $1,200 monthly in SSDI, Jose does not have income, and Jamal earns $100 monthly.

Individual	Household Income
Jordan	$1,200
Jose	$0
Jamal	$0 (Jose does not have income and Jamal's annual income of $1,200 does not exceed the tax filing threshold)

Example 4:
Amir (42) and Amiya (45) are married and live with Amiya's children from a previous relationship, Brynn (22) and Breanna (16). Amir does not work and Amiya has an annual salary of $45,000. Brynn earns $200 weekly at her job.

Individual	Household Income
Amir	$3,750 ($45,000 / 12 = $3,750 monthly)
Amiya	$3,750 ($45,000 / 12 = $3,750 monthly)
Brynn	$860 ($200 x 4.3 = $860 monthly)
Breanna	$3,750 ($45,000 / 12 = $3,750 monthly)

Step 4 – Compare

Using the most-current FPL charts available on the Department of Social Services' site, compare the individual's total monthly household income to the individual's coverage category and household size. If the individual's income is less than or equal to the income limit, the individual is presumptively eligible.

Section 4 – Results

It can be helpful to utilize the APPENDIX 2: CHECKLIST & INCOME QUICK GUIDE as a final tool in this process.

Notice Requirements

At the time of eligibility determination, you must give the individual immediate written notice of whether they are approved or denied coverage.

Denial Notice

If the individual is not eligible for HPE, you must complete the Applicant Notice of Denial (Appendix 4) that explains the reason for the denial. The individual may not appeal the HPE determination. They may still have their application sent to the Department of Social Services as outlined below.

Approval Notice

If the individual is determined eligible for an HPE period, you must complete the Applicant Notice of Eligibility (Appendix 3). This can be used by individuals as proof of coverage to obtain Medicaid-covered services. It also serves as their notice that this benefit is temporary and of the date that coverage will end.

Notifying the Department of Social Services

Qualified hospitals are required to notify the Department of Social Services' Division of Economic Assistance of HPE approvals *within 2 working days* with the following items:

1. Presumptive Eligibility Application
2. Presumptive Eligibility Worksheet
3. Applicant Notice of Eligibility

The above must be submitted by fax (605) 773-7183 to:

Department of Social Services
Division of Economic Assistance
ATTN: Presumptive Eligibility

Failure to submit the items within 2 working days could result in denied claims.

Full Medicaid Application

All applicants, whether determined eligible for an HPE period or not, must be assisted with completing and submitting a full Medicaid application if they elect to do so. This is optional.

Individuals should be informed they can have their application sent to the Department of Social Services in order for the Division of Economic Assistance to make a full Medicaid/CHIP eligibility determination. Additional information may be requested of the individual to determine eligibility for all available medical programs, not just those included in this guide.

If the individual chooses to complete and submit a full application to the Department of Social Services, the hospital must assist in assuring the application is submitted within *2 working days.*

You may submit the application by fax to (605) 773-7183 or by mail to the following address:

Department of Social Services
Division of Economic Assistance
ATTN: Presumptive Eligibility
700 Governors Drive
Pierre, SD 57501

Applications may also be submitted by phone at (605) 773-4678, by email to DSS-MEDELIG@DSS.STATE.SD.US, by mail to any Department of Social Services, in person at any South Dakota Department of Social Services, and by fax to (605) 773-7183 or any South Dakota Department of Social Services.

Address, phone number, and fax information for all South Dakota Department of Social Services can be located at https://dss.sd.gov/findyourlocaloffice/.

APPENDIX 1: PRESUMPTIVE ELIGIBILITY WORKSHEET

A separate worksheet must be completed for each individual applying for presumptive eligibility.

Presumptive eligibility determination for: _____

SECTION ONE – Non-Financial Eligibility

☐ The applicant is not currently eligible for South Dakota Medicaid and has not received Presumptive Eligibility coverage within the last 24 months from the date of application. If pregnant, the applicant has not received presumptive eligibility for this pregnancy.

☐ The applicant is a U.S. Citizen or Qualified Non-citizen and resident of South Dakota.

SECTION TWO – Applicant Coverage Group (check one)

☐ Low-Income Families (Parent and Other Caretaker Relatives)
☐ Medicaid Children under Age 19
☐ Pregnant Women
☐ South Dakota Medicaid for Youth Formerly in Foster Care
☐ Breast and Cervical Cancer Program
☐ Medicaid Expansion – Adult Group

SECTION THREE – Eligibility Calculation (not required for Former Foster Care)

Step	Description	Amount
1	Applicant's household size	_____
2	Income limit for the household size & coverage group (see below)	_____
3	Total monthly household income	_____
4	Is monthly household income equal to or less than the income limit?	☐ Yes ☐ No

Income Limit Chart (2023 FPL)				
HH Size	**Low-Income Families**	**Medicaid Children Under 19**	**Pregnant Women or Medicaid Expansion – Adult Group**	**Breast and Cervical Cancer Program**
1	$ 590	$ 2,273	$ 1,677	$2,430
2	$ 740	$ 3,074	$ 2,268	$3,287
3	$ 842	$ 3,875	$ 2,859	$4,143
4	$ 941	$ 4,675	$ 3,450	$5,000
5	$ 1,042	$ 5,476	$ 4,042	$5,857
6	$ 1,145	$ 6,277	$ 4,633	$6,713
7	$ 1,244	$ 7,078	$ 5,224	$7,570
8	$ 1,343	$ 7,879	$ 5,815	$8,427
Each Additional (approx.)		$801	$592	$858

SECTION FOUR – RESULTS

☐ Applicant is presumptively eligible.
HPE Start Date: _____
Date of HPE Determination: _____

☐ Applicant is not presumptively eligible for the following reason: _____

APPENDIX 2: CHECKLIST & INCOME QUICK GUIDE

HPE CHECKLIST

Hospitals are responsible for identifying individuals who may be eligible for an HPE period. Once you have identified an individual who may be eligible for coverage, you must complete the following steps:

HPE Eligible Population

☐ The person has not received HPE within the HPE time frame restrictions.
☐ The person is not currently enrolled in Medicaid.

General Requirements

☐ The person has a coverage group.
☐ The person is a resident of South Dakota.
☐ The person is a U.S. Citizen or Qualified Non-Citizen.
☐ The person has income below the income limit for their household size and coverage group.

Application

☐ The person has completed and signed the HPE application.
☐ The hospital has completed the Presumptive Eligibility Worksheet for each applicant.

Noticing

☐ The hospital has issued the person a notice of approval or denial immediately after determination.
    ☐ If approved, the hospital has submitted a copy of the approval and other required documents within two business days to the Department of Social Services.

☐ The hospital has offered to assist the individual with completing and submitting an application and has explained the benefits of a full Medicaid/CHIP determination by the Department of Social Services.
    ☐ If the person chooses to complete and submit an application, it has been submitted to the Department of Social Services within two business days.

INCOME QUICK GUIDE

Instructions for Hospitals: Refer to the following table when making HPE determinations based on the information required in the HPE application.

1. Determine the household size for each application and potential coverage groups.
2. Count the gross monthly income (before taxes) of everyone included in the household size for the specific coverage group.
3. If the applicant's income is equal to or under the income limit for their coverage category, the applicant is considered financially eligible.

Household Size

If the applicant is under age 19, their household includes (if living with):	If the applicant is age 19 or older, their household includes (if living with):
• The individual • The individual's children • If pregnant, the number of unborn children of the individual • The individual's spouse (if married) • Parent(s) – biological, adoptive, and step • Any sibling under the age of 19	• The individual • If pregnant, the number of unborn children of the individual • The individual's spouse (if married) • Children under the age of 19 – biological, adoptive, and step

Coverage Groups

Coverage Group	Eligibility Criteria
Low-Income Families (Parents and Other Caretaker Relatives)	Individuals of any age living with and caring for a related (biological, adopted, or step) child or grandchild, sibling, nephew, niece, or first cousin under age 19 with household income at or below the income threshold.
Medicaid for Children Under Age 19	Children under age 19 with household income up to 187% FPL.
Pregnant Women	Individuals who attest that they are pregnant and have household income at or below the 138% FPL threshold.
South Dakota Medicaid for Youth Formerly in Foster Care	Individuals aged 18 to 26 who were in DOC or CPS custody under the responsibility of any State or Tribe on their 18th birthday and leave foster care. There is no income test.
Breast and Cervical Cancer Program	Individuals aged 30 through 64 who have been found in need of treatment for breast or cervical cancer, are not eligible for Medicare Part B, and attest to income below 200% FPL.
Medicaid Expansion – Adult Group	Adults at least age 19 but less than 65 who are not pregnant, not entitled to or enrolled in Medicare, and who have household income at or below the income threshold of 138% FPL.

Countable & Non-Countable Income

Countable Income	Non-Countable Income
• Wages/tips • Net self-employment income • Pensions and annuities • Social Security (Old-Age, Survivors, and Disability Insurance – excluding SSI) • Unemployment	• Federal Veteran's Benefits • Child Support • Worker's Compensation • Scholarships, fellowship grants, and awards used for educational purposes. • Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) • Supplemental Security Income (SSI)

Income Limit Chart (2023 FPL)				
HH Size	**Low-Income Families**	**Medicaid Children Under 19**	**Pregnant Women or Medicaid Expansion – Adult Group**	**Breast and Cervical Cancer Program**
1	$ 590	$ 2,273	$ 1,677	$2,430
2	$ 740	$ 3,074	$ 2,268	$3,287
3	$ 842	$ 3,875	$ 2,859	$4,143
4	$ 941	$ 4,675	$ 3,450	$5,000
5	$ 1,042	$ 5,476	$ 4,042	$5,857
6	$ 1,145	$ 6,277	$ 4,633	$6,713
7	$ 1,244	$ 7,078	$ 5,224	$7,570
8	$ 1,343	$ 7,879	$ 5,815	$8,427
Each Additional (approx.)		$801	$592	$858

There is no income test for the South Dakota Medicaid for Youth Formerly in Foster Care.

APPENDIX 3:
APPLICANT NOTICE OF ELIGIBILITY

[HOSPITAL LETTERHEAD]

Medicaid Notice of Presumptive Eligibility

[Date]

[Applicant Name]
[Applicant Address]
[Applicant CITY/STATE/ZIP]

The following individual has been determined presumptively eligible to receive Medicaid coverage and is able to access coverage as of the date of the presumptive eligibility determination. This notice serves as proof of coverage and eligibility as of this date.

Coverage is temporary unless you take action. If you want to apply to continue with South Dakota Medicaid coverage after your temporary eligibility ends, a completed application must be submitted to the South Dakota Department of Social Services no later than _____ (the last day of the month following the month this notice was signed). If the application is not received by that date of _____, eligibility will stop on that date.

If you are found eligible for ongoing Medicaid coverage by the Department of Social Services, your Presumptive Eligibility period will end effective the date that determination is made.

Individual's Name	Individual's Aid Category (Check one)
Last: _____ First: _____ Middle: _____	☐ Low-Income Families (Parents and Other Caretaker Relatives) ☐ Medicaid for Children Under Age 19 ☐ Pregnant Women ☐ South Dakota Medicaid for Youth Formerly in Foster Care ☐ Breast and Cervical Cancer Program (*the hospital must be an All Women Count! Program provider)* ☐ Medicaid Expansion - Adult Group

- Pregnant Women are only covered for ambulatory prenatal care. Ambulatory prenatal care includes pregnancy-related Medicaid covered services except charges associated with inpatient care in a hospital or other medical institution and charges associated with delivery of the baby

This is not a formal ongoing Medicaid eligibility determination. See checked section below regarding your Presumptive Eligibility period:

☐ Your completed application for medical assistance has been sent to the South Dakota Department of Social Services for a formal Medicaid eligibility determination. Your presumptive eligibility period will end when the Department of Social Services makes a formal eligibility determination for Medicaid. You will receive a notice from the Department of Social Services regarding the outcome of this determination.

☐ You must submit a complete application to the Department of Social Services/Division of Economic Assistance to have a formal ongoing Medicaid eligibility determination processed. We have provided you with the application.

You may submit the application by fax to (605) 773-7183 or by mail to the following address:

Department of Social Services
Division of Economic Assistance
ATTN: Presumptive Eligibility
700 Governors Drive
Pierre, SD 57501

Applications may also be submitted by phone at (605) 773-4678, by email to DSS-MEDELIG@DSS.STATE.SD.US, by mail to any Department of Social Services, in person at any South Dakota Department of Social Services, and by fax to (605) 773-7183 or any South Dakota Department of Social Services.

Address, phone number, and fax information for all South Dakota Department of Social Services can be located at dss.sd.gov/findyourlocaloffice.

This Presumptive Eligibility determination was made by:

Qualified Hospital Name: _____

Designated Employee Name: _____

Phone Number: _____

Email Address: _____

APPENDIX 4:
APPLICANT NOTICE OF DENIAL

[HOSPITAL LETTERHEAD]

Medicaid Presumptive Eligibility Notice of Denial

[Date]

Applicant Name
Applicant Address
Applicant CITY/STATE/ZIP

The application for presumptive eligibility has been denied for the following applicant because:

[Applicant Name]

☐ your family income is over the allowable limit
☐ you are not a resident of South Dakota
☐ you are not a United States Citizen or Qualified Alien
☐ you did not meet a Medicaid eligibility category
☐ you have asked that your application be withdrawn
☐ you have not provided the information we requested
☐ Other, indicate reason: _____

Temporary eligibility determinations are final
There is no right to appeal a temporary eligibility decision.

You may re-apply for Medicaid benefits at any time.

- Online Applications are available at: dss.sd.gov/applyonline or https://www.healthcare.gov/
- Paper applications are available at this facility or available at your local Department of Social Services office. A list of local offices can be found at: dss.sd.gov/findyourlocaloffice
- You may also apply by phone, to do this please contact your local DSS office.

This Presumptive Eligibility determination was made by:

Qualified Hospital Name: _____
Designated Employee Name: _____
Phone Number: _____
Email Address: _____