# Nebraska Presumptive Eligibility Determination Form



#### Are you eligible for Presumptive Medicaid Coverage?

Use this form to find out if you qualify for temporary medical coverage under Nebraska Medicaid's Presumptive Eligibility Program. The Presumptive Eligibility Program offers you free health care coverage while you apply for Medicaid and await your eligibility determination.

If you are found eligible for the Presumptive Eligibility Program, you must complete and submit a Medicaid application (see below) to find out if you qualify for continuing Medicaid coverage. While waiting for your Medicaid application to be processed, you may obtain services through the Presumptive Eligibility Program.

#### Who can qualify for Presumptive Medicaid Coverage?

You may qualify for Presumptive Medicaid Coverage if you meet the following requirements:

- Your income is below the standard for your group.
- You are a U.S. citizen, U.S. national, or an eligible immigrant.
- You are not currently enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- You have not had Presumptive Medicaid Coverage in the past two years or during your current pregnancy.
- You are in one of the following groups that qualify for Presumptive Medicaid Coverage:
  - Children under age 19
  - Pregnant women
  - Parents and caretaker relatives
  - Adults age 19-64
  - People who were enrolled in Medicaid and in foster care in Nebraska and aged out at 19 years of age
  - Women in treatment for breast and cervical cancer

#### How do I apply for Medicaid?

Any individual can apply for Nebraska Medicaid in the following ways:

- Online via healthcare.gov or at ACCESSNebraska.gov.
- Via paper using the single streamlined application (MILTC-53).
- In person by completing an application at a local DHHS office or with a Social Services Worker.
- Over the phone by contacting your ACCESS Nebraska phone number.

Omaha: 402-595-1178Lincoln: 402-473-7000

Other areas: 1-855-632-7633

#### Questions?

Contact Nebraska DHHS using the numbers listed above if you have questions or to complete your Medicaid application.



Address.

#### **Medicaid and Long-Term Care**

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Phone:

#### SECTION 1: This entire form should be completed by a qualified hospital staff member.

Please list all members of the family living in the home together. Parents in the home include biological, step, or adoptive. If more space is needed, attach an additional sheet of paper.

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Name	Date of Birth (MM/DD/YYYY)		Gender M/F	Pregnant? Y/N		Fetal Number		Expected Due Date (MM/DD/YYYY)		
SECTION 4:  DO NOT COMPLETE	TUIS SECTIO	N DEE	OPE COM	DI ETING	2 0 0	CTIONS 2	AND 1	ON D	AGE 2	
I (The qualified Presumptive Eligibil										
presumptively eligible. (Do not com	plete Section 4	if the	client is det	ermined i	neli	gible.)	ı			
Name		Category of Eligibility		(M	Date of B (MM/DD/Y				*Note: A presumptively eligible pregnant	
									woman is eligible for ambulatory	
									prenatal care only	
									*Pregnancy	
									providers may only authorize	
									presumptive eligibility for	
									pregnant women	
Please note: Only ners	one cortified		ider Inform		2W 2	uthorize n	roeum	ntivo e	eligibility	
Please note: Only persons certified as approved providers may aut Name:									ovider Number:	
						ı				
Address:						Phone:				
Signature: (Provider may sign only after client has been approved and signed page 2)							Date of PE Determination:			
			-1							

**NOTICE TO PROVIDERS:** Please accept this form as proof of temporary Medical coverage.

To check Medical presumptive eligibility please call the Medicaid Eligibility Line (NMES) at 1-800-642-6092

Please note: There may be a delay in Presumptively Eligible cases appearing as eligible

Be advised that pregnant women are eligible for ambulatory prenatal care only.

**NOTICE TO APPLICANT:** Show this form to providers of services as proof of medical coverage. You will NOT be issued a Medicaid card. This coverage is temporary. If you are interested in receiving full Medicaid coverage, you MUST complete a Medicaid application.



### **Medicaid and Long-Term Care**

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**SECTION 2: Complete this section for household members.** 

Citizenship/Immigration status is required for applicants only. SSN/A Number is optional.

Name (Last, First)	US Citizen OR Eligible Immigrant (Y/N)	SSN/Immigration Status and A Number *Optional	Tax Filing Status (See options)	Relationship to applicant	Nebraska Resident (Y/N)						
				SELF							
Tax Filing Status Abbreviations:		<u> </u>	I .	l							
Single Tax Filer - <b>S</b>	Married Filing	Seperately - MS	Ta	x Dep. of Other	- DO						
Married Filing Jointly - <b>MJ</b>		Non Tax Filer - <b>NF</b>									
Is anyone requesting assistance currently covered by Medicaid? If yes, who:  Are you applying as a Parent or Caretaker Relative?  Did you age out of Foster Care while on Nebraska Medicaid?  Have you been diagnosed with breast or cervical cancer?  Note: Only CDC accepted participants for the National Breast and Cervical Cancer Early Detection Program may approve Presumptive Eligibility for breast and cervical cancer patients.											
SECTION 3: Declaration of Income (Please note what deductions were used in the computation.)											
Total Monthly Gross Income \$		4. Total Coun	table Income	\$							
2. Total Net Self-Employment Income \$		5. Total Dedu	ctions	\$							
3. Total Monthly Unearned Income \$		6. Line 4 min	us Line 5	\$							
Compare line 6 to the FPL for the individual's Medicaid category and household size to determine eligibility.											
When this form is signed I agree that for the purpose of complying with Neb. Rev. Stat. 4-108 through 4-114, I hereby attest that my response and the information provided on this from and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.											
NOTICE OF APPEAL RIGHTS: This is not an application for Medical Assistance. If you want Medical Assistance you are required to complete an application by the last day of the month following the Date of PE Determination listed in Section 4 of this document. Failure to apply will cause this presumptive eligibility to end without notice. You will be responsible for medical expenses incurred from this date forward.  If for any other reasons the agency determines that you are ineligible for Medical Assistance, this presumptive eligibility will end without notice.											
These actions are not subject to appeal.											
To apply for Medical Assistance, go to ACCESSNebraska.ne.gov or call 1-855-632-7633.											
SIGN HERE: (Signature or Mark of Applicant -	Da	Date:									
SIGN HERE: (Signature or Witness if needed)											