Hospital Presumptive Eligibility
Medi-Cal Application

Instructions: To find out if you can get Hospital Presumptive Eligibility (PE) benefits today, please answer all the questions on this form. This is a voluntary program. All information is confidential. The Hospital PE Program gives patients temporary, no-cost Medi-Cal coverage for up to 60 days.

Important Reminder! *The individual must submit a completed insurance affordability application before their PE period terminates in order to be eligible for continued coverage beyond the 60-day PE period and/or coverage back to 3 months from the date of the insurance affordability application.*

Section 1. Tell us about the patient. Patient Personal and Contact Information

Hospital Official Use Only	**Date First Treated** *(mm/dd/yyyy)*: _____

Last Name	**First Name**	**Middle Name**	**(Jr. Sr. II. etc.)**

Date of birth *(mm/dd/yyyy)*	**Social Security Number (*optional*)**	**Male**	**Female**
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☐ **If homeless, check the box and tell us where we can reach you in the home address field below.**	☐ **If "Safe At Home" participant, check the box and answer the questions below.** **1. What is your P.O. Box address, if known?** _____ **2. What is your Safe At Home Participant ID, if known?** _____

Home Address *(number & street)*	**City**	**State**	**ZIP Code**
Mailing Address *(if different than above)*	**City**	**State**	**ZIP Code**

Living in California? ☐**Yes** ☐**No**	**County living in?**

Best contact phone number	**Other phone number**	**Email address**

What language does the patient speak best?	**What language does the patient read best?**

	Yes	**No**
1. Does the patient have a State of California Benefits Identification Card (BIC), also known as a Medi-Cal Card? **If yes, what is the identification number on the card, (if available)?** _____		
2. Is the patient between the ages of 18 - 26 and had Foster Care the month of their 18th Birthday?		
3. Is the patient a parent of a child or caretaker relative of a child that lives with the patient?		
4. Is the patient pregnant? **If yes, the expected due date (mm/dd/yyyy)?** _____ **How many babies expected, if known?** _____ ***Note:*** *If the patient is pregnant, services are limited to ambulatory, prenatal services.*		
5. If pregnant, has the patient received presumptive eligibility services during this current pregnancy?		

Section 2. Patient Household and Income Information

How many family members live in the patient's household? (*Include parent, spouse, and any children under age 21 living in the household*)_____	**How much is the patient's household income before taxes?** **$**_____**Monthly or $**_____**Yearly**

Section 3. Signature and Declaration

By signing, I declare that what I say below is true and correct.

▪ I have read and understand this Hospital PE Medi-Cal Application. ▪ I have received the insurance affordability application.	▪ I understand that I must complete and submit the insurance affordability application the end of my PE period in order to be eligible for continued coverage. ▪ The information I provided is true, correct, and complete.

Signature of patient or parent/spouse/guardian/emancipated minor	**Relationship to patient** *(if applicable)*	**Date** *(mm/dd/yyyy)*

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information contained in this application is the California Department of Health Care Services, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413 and Covered California. This information may be shared with the County Department of Social Services in the county in which the individual resides. The individual's medical information will be kept with the Hospital Presumptive Eligibility provider and Covered California.

INSTRUCTIONS
Hospital Presumptive Eligibility Medi-Cal Application

Section 1. Tell us about the individual requesting service. Personal and Contact Information

Date First Treated – Hospital Official Use Only

- Enter the date the individual is first treated within the hospital facility if the submission date of this application differs from the date services were provided. The delay in submitting the application shall be no more than one month from the date of service. Provide reason for delay in submitting the application:

Reasons Application Delayed (Drop Down Menu)	Description
Applicant unavailable	Applicant unable to complete/sign application.
Authorized Rep unavailable	Applicant did not have representative or authorized representative to sign on his/her behalf.
Hospital staff unavailable	Designated hospital employee not available to complete on-line application.
Application Portal not available	Online Application Portal not available.

Individual's Personal Information

- Enter the individual's Last Name, First Name, Middle Name and Jr., Sr., II, if indicated, otherwise leave blank.
- Enter the individual's date of birth (month/date/full year). (Example: 07/07/2014)
- Enter the individual's Social Security Number, if available. Enter a check mark to indicate the individual's gender.

Individual's Contact Information

- Check the box if the individual is homeless. All applicants should complete the home address or mailing address field.

Safe At Home Questions

- Check the box if the individual is a "Safe At Home" participant.
  1. Enter the individual's P.O. Box, if available. Otherwise, select "Unknown".
  2. Enter the Safe At Home Participant ID, if available.

> **Important - Safe At Home** program is California's confidential address program, which helps victims of violence by providing a free post office box mail service. Hospital PE applicants, who are Safe At Home participants, are allowed to provide their Safe at Home P.O. Box address instead of providing their residence address. Safe At Home participants have a participant ID card.

Individual's Address:

- Enter the individual's home address. (If homeless, enter an alternative address).
- Enter the individual's mailing address if different from the home address.
- Check Yes or No if the individual is living in California.
- Enter the name of the County where the individual is living. (If homeless, individual's designated County general area)
- Enter the individual's phone numbers with area code, if available.
- Enter the individual's Email address, if available.

INSTRUCTIONS
Hospital Presumptive Eligibility Medi-Cal Application

Section 1. Continued — Tell us about the individual requesting service. Personal and Contact Information

Questions 1 – 5

1. Check Yes or No if the individual has a BIC. If yes, enter the card number, if available.
2. Check Yes or No if the individual is between the ages of 18 - 26 and had Foster Care the month of their 18th Birthday.
3. Check Yes or No if the individual is a parent of a child (under the age 18) or caretaker relative of a child that lives with the individual.
4. Check Yes or No if the individual is pregnant.
   - If pregnant, enter the expected due date, if available.
   - Enter the number of babies expected, if available.
5. Check Yes or No if the individual is pregnant and has received presumptive eligibility services during this current pregnancy.

Section 2. Individual's Household and Income Information

- Enter the total number of family members living in the individual's household. Family members include the individual, parents of individual under 21 if living in the home, spouse of the individual, and any children under age 21 living in the household.
- Enter the total income received in the individual's household before taxes, either monthly income or yearly income.

Section 3. Signature and Declaration

- State and federal laws require the individual's signature. The signature indicates that the declarations and answers are truthful and correct. If the individual cannot sign the application, a family member may sign the application on the individual's behalf.