NOTICE OF DECISION ON YOUR PRESUMPTIVE MEDICAID ELIGIBILITY APPLICATION FOR HOME HEALTH OR COMMUNITY HOSPICE CARE SERVICES

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CEI
CASE NUMBER / CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPI

This Department has made a decision concerning your Medicaid application for presumptive eligibility dated _____. We are sending this notice to tell you that this Department will:

+-+
+-+ ACCEPT your presumptive Medicaid eligibility application from _____ to _____ pending verification of information in your application.

Please note that Medicaid does not cover hospital-based clinic services, hospital emergency room services, acute hospital inpatient services (except when provided as part of hospice care), and bedhold during the presumptive eligibility period.

Your total unverified monthly income is $_____. The difference between your net income and the Medicaid level is $_____. This is called your monthly surplus income. Each month, Medicaid will pay medical expenses above this figure that are incurred during the month. This figure will be adjusted as necessary to the extent that your verified income is higher or lower than you have indicated.

In addition to any income contribution, $_____ of excess resources must be contributed toward the cost of care from _____ to _____.

If, upon full determination of eligibility, it is established that you are not eligible for Medicaid, any medical bills paid on your behalf will be subject to recovery action by the agency. In addition, the provider may seek reimbursement for that portion of the bill not paid by Medicaid.