Presumptive Eligibility for Children Screening Determination Letter

_____/_____
Parent/Guardian name Applying Child(ren)'s name(s)

_____
Applying Child(ren)'s names (cont.)

_____/_____/_____/_____
Street Address/Apt # City ZIP County

/ / /
Phone/Message Number Date of Presumptive Eligibility Screening/Determination

To the Applying Parent/Guardian:

According to our review, (names) _____, **are presumptively eligible** for covered Medicaid services until the Local Department of Social Services (LDSS) completes a full determination of their ongoing Medicaid eligibility.

Based on this determination, covered Medicaid services have been temporarily authorized from today's date of_____/_____/_____. In order for your children to continue to get Medicaid, you must complete a full Medicaid application. This center or a partner Facilitated Enroller will assist you in completing this process.

If determined by the LDSS to be eligible for ongoing Medicaid coverage, you will receive a notice and a Medicaid ID card for your child(ren) approximately 10 days after the full determination is completed.

We are able to provide most covered Medicaid services through our Health Care Centers and associated medical partners.

It is important that you complete all of the eligibility requirements for your child(ren)'s application for ongoing Medicaid, including returning requested documentation to us within _____days. We will forward your Medicaid application package including all of the documents you have provided us to _____ County DSS for a full determination of ongoing Medicaid coverage.

Presumptive Medicaid for Children ends at age 19. If your child is between 18 and 19 years old and ongoing Medicaid is not determined by his or her 19th birthday, your child's presumptive coverage will end at the end of the month in which he/she turns 19.

If the LDSS determines your child(ren) is/are not eligible for ongoing Medicaid coverage, your child(ren)'s presumptive eligibility coverage will end, and you will receive a notice informing you of the end date. Please be aware that only one Presumptive Eligibility period for each child is allowed in a 12 month period.

According to the information you have provided us, we are **not** able to determine that (names) _____ is/are **presumptively eligible** for Medicaid services at this time. You may apply for Medicaid at _____ County Department of Social Services, where a complete eligibility determination can be done. You may also apply for Medicaid/CHPlus with a Facilitated Enroller. Call the Growing Up Healthy Hotline at 1-800-522-5006 for more information.

(Names) _____ is/are **not presumptively eligible** for Medicaid services at this time because your child(ren) has/have already received Medicaid Presumptive Eligibility within the last 12 months. You may apply for Medicaid at _____ County Department of Social Services where a complete eligibility determination can be done. You may also apply for Medicaid/CHPlus with a Facilitated Enroller. Call the Growing Up Healthy Hotline at 1-800-522-5006 for more information.

_____ _____
Signature of Screening Interviewer Qualified Entity's Name - Please Print

_____ _____/_____/_____
Qualified Entity's Location Date of PE Screening/Determination

_____ _____
Qualified Entity's Phone Number NYS DOH Authorization Names/Numbers