NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Presumptive Eligibility (PE) for Children Screening Form

SECTION 1 APPLICANT'S PERSONAL INFORMATION

Parent/Guardian First Name, Middle Initial, Last Name			Phone Number ( )
Home Address Street Apt. No.	City	Zip Code	County of Residence

PE Determination Date / /	Authorization Approval Number / Name
Application Site	

Child(ren)'s Name(s) (First Name, Middle Initial, Last Name)	**Date of Birth** (MM/DD/YY)	**Sex** M or F	**Social Security Number** (Optional)
	/ /		
	/ /		
	/ /		
	/ /		

(1) Are all children being screened U.S. Citizens? ☐ Yes ☐ No (2) If no, are they lawfully present and a NYS resident? ☐ Yes ☐ No
Please list any children who are not U.S. citizens or who are not lawfully present:

If you are not documented, or are a temporary non-immigrant, who is not a NYS resident, you may be able to get Medicaid for the treatment of an emergency medical condition or a pregnancy, if you are determined to be otherwise eligible.

SECTION 2 HEALTH INSURANCE

Do any applying children listed above have or have recently applied for: ☐ **Medicaid** ☐ **Medicare** ☐ **Child Health Plus**

If so, who:_____ **Place and date of application if not yet in receipt of coverage:** _____

Optional: Do any applying children listed above have other private health insurance? ☐ **Yes** ☐ **No** ☐ **I Don't Know** **If Yes:**

Name of Policy Holder/Subscriber	Relationship to Child(ren)
Insurance Company Name.	Group/Policy Number
Child(ren) Covered	

SECTION 3 FAMILY SIZE

Enter # of parent(s) of applying children who are living in the household _____

Enter 1 if child is not living with a parent but with a caretaker relative who will also be applying for MA (i.e. grandparent, aunt, uncle, adult sibling, etc.) _____

Enter # of children who live in applying child(ren)'s household who are under age 21, including applying child + _____

Total # in Household = _____

SECTION 4 INCOME

Household's **total monthly gross** income (Before taxes and any deductions) $ _____

(Include, wages, tips, commissions, Social Security*, alimony, unemployment benefits, etc.)

Do not include child support payments, grants or loans of students, or any Temporary Cash Assistance or SSI payments.

**Do not include Social Security income received by a dependent child.*

SECTION 5 PRESUMPTIVE ELIGIBILITY DETERMINATION

Compare the household's gross monthly income amount in Section 4 to current monthly income levels for the Family Size in Section 3.

If gross monthly income is less than or equal to 154% of the FPL – Children age 1 through 18
☐ Yes – Presumptively Eligible; List Name(s):
☐ No – Not Presumptively Eligible; List Name(s):

If gross monthly income is less than or equal to 223% of the FPL – Infant under age 1
☐ Yes – Presumptively Eligible; List Name(s):
☐ No – Not Presumptively Eligible; List Name(s):

☐ Ineligible for anything other than the treatment of an emergency medical condition; cannot have presumptive eligibility; List Name(s):

Make referral to State Child Health Plus Program (see information below)

SECTION 6 ENTITY / SCREENER INFORMATION

Screener Name	Screener Signature
Qualified Entity Agency Name	
Address	Phone Number ( )

If ELIGIBLE, submit to Department of Social Services within 21 days.
If INELIGIBLE, make referral to NY State of Health 1-855-355-5777

INSTRUCTIONS FOR COMPLETING SCREENING FORM

PLEASE TYPE OR PRINT LEGIBLY

Section 1 – Applicant's Personal Information

Name: List name of parent(s)/guardian(s) of the applying child(ren)

Phone Number: Enter contact/message number

Address: List the address where the child(ren) live(s) including house number, street name, apt number, city, and zip code

County of Residence: Enter the county in which above address is located or NYC if a New York City resident

PE Determination Date: List today's date

Application Site: List the name of the Qualified Entity Site

Authorization Number/Name: Call NYSDOH – 1-888-375-1912 to obtain authorization number for children who determined presumptively eligible. Document the name of the person who provided you with the number.

Child(ren)'s Name(s): List all children who are being screened for PE for Children

DOB: List month, day, and year of child(ren)'s birth

Sex: Indicate the appropriate sex in this space

Social Security Number: Enter SSN (optional). Note: SSN or proof of application for SSN will have to be provided for full Medicaid determination.

Citizenship/Immigration Status: (1)/(2)Check boxes as appropriate. Explain that Medicaid is available to people who are US Citizens or are lawfully present and a NYS resident. Others may receive treatment only for an emergency medical condition or a pregnancy. If unsure of the child(ren)'s status, ask if they have any of the following: a Green Card, a Passport, a Visa or any other immigration document. Also, ask if they are working with immigration services to get permanent status.

Section 2 – Health Insurance

Complete as much information as known. Inquire about recent applications for Medicaid and Child Health Plus. If yes, indicate when and where the application was taken. Information about private health insurance is optional for PE screening but will be required upon application for full coverage.

Section 3 – Family Size

Enter numbers to identify number of persons living in the household. If the mother of the applying child is pregnant, count as 2 (mom plus the unborn child). Count the legal spouse and/or father of the child, if they live in the household. Count 1 for Caretaker Relative (if no parents live in the household) and if they will also be applying for Medicaid. Count all of the children under age 21 in the household whether or not they are applying. Do not count persons who receive Temporary Cash Assistance or SSI cash assistance.

Section 4 – Income

Enter the total amount of the monthly gross (before taxes and deductions) household income. Verification is not required for PE. Weekly wages are converted to monthly by multiplying by 4.3333. Do not count grants or loans of students, Temporary Cash Assistance or SSI Case Assistance. Do not include Social Security income received by a dependent child. Enter caretaker relative's income if they are in the household count and are applying for MA.

Section 5 – Presumptive Eligibility Determination

Compare the gross monthly income with the income standards chart for the appropriate household size calculated in Section 3 and percentage of the Federal Poverty Level for the age of each child. If the child(ren) is found to be eligible, the corresponding box(es) is checked, the child(ren)'s name(s) listed and a Presumptive Eligibility Screening Determination letter is given to the applying parent or guardian with the names of the children who are Presumptively Eligible for Medicaid. This letter advises households of next steps to take to apply for ongoing Medicaid. This completed screening form, an accompanying Medicaid application, determination letter and all documentation are forwarded to the appropriate county Local Department of Social Services (LDSS) within 21 days for further review and a determination for ongoing Medicaid.

If any child applying is ineligible, list the name of the child(ren) who is ineligible and refer to the phone numbers at the bottom of the screening form for information on applying for Child Health Plus, and/or refer to the nearest Navigator for application assistance. If all children on the screening are ineligible, do not send the PE screening form to the LDSS, but retain copies in a locked, secure area.

Section 6 – Entity/Screener Information

Enter screener's, screener's signature, name of Qualified Entity, address and phone number. **Screener's signature is required to authorize Presumptive Eligibility.**

If ELIGIBLE, submit to Department of Social Services within 21 days.
If INELIGIBLE, make referral to State Child Health Plus Program. Call 1-800-698-4KIDS (1-800-698-4543).