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

Home Address Street Apt. No.

City

Zip Code County of Residence

Phone Number

PE Determination Date / /

Application Site

Authorization Approval Number / Name

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

Name of Policy Holder/Subscriber

Insurance Company Name.

Relationship to Child(ren)

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

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 4  INCOME

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

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.