LDSS-4150 (12/08)

MEDICAID PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN SCREENING CHECKLIST

1. APPLICANT'S NAME: _____ (LAST / FIRST / M.I.) ADDRESS: _____ COUNTY OF RESIDENCE: _____	DATE OF BIRTH (M / D / Y) PRESUMPTIVE DETERMINATION DATE (M / D / Y) HOME PHONE (INCLUDE AREA CODE) ( )	EDC (M / D / Y) SOCIAL SECURITY NUMBER (Optional – please provide if available) MESSAGE PHONE

2. Does applicant currently have Medicaid or Family Health Plus coverage? ☐ **NO** ☐ **YES**
   If 'Yes', ***STOP!*** **See Section 2 of Instructions.**
3. Check if applicant has recently (within the last 3 months) applied for: ☐ Medicaid ☐ Family Health Plus ☐ Cash Assistance

   If 'Yes', When? _____ Where? _____ Case Name _____

4. If applicant has applied for Family Health Plus, and her eligibility has not been determined or she has not heard from her health plan yet, does she need ongoing prenatal care? ☐ Yes ☐ No
5. Does applicant have Health Insurance Coverage: ☐ Yes ☐ No Does not want to use, claims good cause ☐

   Type: ☐ Inpatient ☐ Outpatient ☐ Dental ☐ Drugs ☐ Other *(specify)* _____

NAME OF INSURANCE COMPANY	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SEX	RELATIONSHIP TO POLICY HOLDER
A.				
B.				

6. Family Size:

   Pregnant Woman..... **2**

   Enter 1 if spouse is in the home . _____

   Enter number of woman's children under age 21 in the home..... + _____

   TOTAL _____

7. a. Household's monthly gross income ..... a. _____
   (Include wages, social security, child support, alimony, unemployment benefits, etc.)

   (Do **not** count wages, grants, or loans of students or Public Assistance or SSI grants)

   b. Deductions (Monthly)
   $90 from earned income only ..... _____

   Child care expenses from employment ($175.00 maximum per child age 2 or over; $200.00 maximum per child under age 2) _____

   $100 from child/ spousal support only .... _____

   Health Insurance..... + _____

   Total Deductions _____ - b. _____

   Net Monthly Income **(a – b)** _____

8. Compare Net Monthly Income (7) for Family Size (6) to Current Monthly Income Levels

Net Monthly Income is:		
	Less than 100% poverty	☐ Eligible for all Ambulatory Medicaid Services
	Less than 200% poverty	☐ Eligible for Ambulatory Prenatal Services **Only**
	More than 200% poverty	☐ Ineligible (Subject to Spenddown)

9. If eligible, Health Plan Choice: _____ Doctor: _____

10. QUALIFIED PROVIDER	NAME	SIGNATURE	
	ADDRESS		PHONE NUMBER

If ELIGIBLE, submit to Department of Social Service with Medicaid application in 5 days.

If INELIGIBLE, make referral to Department of Social Services for determination.

INSTRUCTIONS FOR COMPLETING SCREENING CHECKLIST

PLEASE TYPE OR PRINT LEGIBLY.

Section 1:

- *Name* – List woman's full legal name.
- *Address* – List address where woman resides, including zip code.
- *County of Residence* – List County in which above address is located.
- *Date of Birth* – List month, day, and year of woman's birth.
- *EDC* – Expected date of confinement or delivery. **This element is required as verification of pregnancy.**
- *Presumptive Determination Date* – List date this form is completed and signed. This element is required to begin reimbursement for presumptive coverage
- *SSN* – Social Security Number of woman (optional).
- *Home Phone* – Complete if applicable.
- *Message Phone* – List phone where woman may receive messages if no home phone.

Section 2:

- Ask the pregnant women if she is currently covered by Medicaid or Family Health Plus (FHPlus). If all services are covered by Medicaid or FHPlus, completion of this form is **not** required.
- If pregnant woman does not currently have full Medicaid or Family Health Plus coverage, complete the Screening Checklist as completely and accurately as possible.

Section 3:

- *Recent Healthcare Coverage History* – If the woman has applied, identify when and where she applied for coverage under any of the programs listed. If in New York State (NYS), give the county where this information is on file. If not in New York State, give State.

Section 4:

- If the woman has applied for FHPlus and her eligibility has not been determined yet, or she has not heard from her health plan, fill out Section 4. If Yes, she must receive Medicaid. If No, Presumptive Eligibility coverage until FHP enrollment. You may need to check with the local department of social services to determine the status of the application.

Section 5:

- *Health Insurance* – complete as much information as possible. Third Party Health Insurance Information must be obtained when applying for Medicaid unless the applicant claims good cause not to cooperate in using health insurance. The applicant may claim good cause not to use health insurance if its use could cause harm to her emotional or physical health or safety or to the health and safety of someone for whom you are legally responsible. In this case, check the "Does not want to use, claims good cause," box.

Section 6: *Family Size* – used to determine the number of family members to be used for income comparisons.

- *Pregnant woman* – Count is always 2 (woman + unborn).
- *Spouse* – Count only if legal spouse is living with woman.
- *Children* – Count woman's other children under 21 who live with her.
  NOTE: Do not count persons who receive Public Assistance or SSI.

Section 7: Income – Total gross monthly Income for all persons counted in Family Size (**Section 6**). Do not include income from any person not counted in Family Size. Verification is not required.

- Wages may be converted from weekly to monthly by multiplying by 4.3333. Grants, loans, and wages received by students as well as Public Assistance and SSI grants are exempt.
- Deductions are computed monthly.
- $90 may be deducted only from earned income (wages)
- Child care expenses may be deducted if required for employment. Deduct the actual amounts paid, up to the maximum listed.
- $100 may be deducted from child support payments received for any children included in Family Size (one $100 deduction per family).
- Cost of health insurance premiums computed monthly may be deducted.
- *Calculation* – Subtract total deductions (b) from total income (a) to find net monthly income for use in Income Comparison.

Section 8: Compare net monthly income from **Section 7** to Monthly Income Levels for appropriate Family Size (**Section 6**).

- Check box corresponding to correct eligibility level.

Section 9. If eligible, place the HMO/PCP Name including the Doctor's name (if known). The HMO/PCP must also be entered on section K of the DOH-4220, Access NY Application or Section I of DOH-4133, Growing Up Healthy.

Section 10: Qualified Provider should type or print name, address, and phone number.
Provider's signature is required to authorized Presumptive Eligibility.