ATTACHMENT VI

NOTICE OF DECISION ON YOUR PRESUMPTIVE MEDICAID ELIGIBILITY APPLICATION FOR COVERAGE OF NURSING FACILITY SERVICES OR INPATIENT HOSPICE CARE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
		OR Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

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

☐ ACCEPT your presumptive eligibility application for Medicaid coverage effective 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. We have calculated the total monthly contribution toward the cost of this individual's care for the periods indicated:

From _____	**To** _____	**From** _____	**To** _____
Gross Monthly Income	$ _____	Gross Monthly Income	$ _____
Deductions	- _____	Deductions	- _____
Net Monthly Income	$ _____	Net Monthly Income	$ _____
Income Allowance Personal Needs Allowance/MA Level	-$ _____	Income Allowance Personal Needs Allowance/MA Level	-$ _____
Contribution to Community Spouse	- _____	Contribution to Community Spouse	- _____
Family Member Allowance(s), or Dependent Household Member(s)	- _____	Family Member Allowance(s), or Dependent Household Member(s)	- _____
Costs of Medical/ Remedial Care	- _____	Costs of Medical/ Remedial Care	- _____
Remaining Available Monthly Income	= _____	Remaining Available Monthly Income	= _____
Contribution from Spouse	+ _____	Contribution from Spouse	+ _____
Restricted Income	+ _____	Restricted Income	+ _____
Total Income Contribution per mo.	$ _____	Total Income Contribution per mo.	$ _____
		Payable to: _____	

In addition to any income contribution, $_____ of excess resources must be contributed toward the cost of care from _____ to _____. Your total monthly contribution toward the cost of care will be adjusted to the extent your verified income/resources are higher or lower than you have indicated. 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.

☐ DENY your Medicaid application for presumptive eligibility, because:

_____

_____

_____

We will contact you to schedule an interview with you to determine your eligibility for regular Medicaid coverage.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS