Healthy Connections

South Carolina Department of Health and Human Services

Medicaid Presumptive Eligibility

PRIORITY PROCESSING
This is not a full Medicaid application

things to know

Who is authorized to complete this application?

- Hospitals have the option to perform Presumptive Eligibility (PE) determinations for select Medicaid coverage as granted by the Affordable Care Act.
- An employee of an authorized hospital may use this application to conduct an eligibility determination on a potentially Medicaid-eligible applicant. Only those employees who have been trained by Healthy Connections are allowed to conduct an eligibility determination.
- To participate in the PE program, hospitals must (i) participate in Medicaid and (ii) not be disqualified. Presumptive eligibility determinations must be performed by a hospital employee, and authority may not be delegated to any non-employee, including employees of affiliated entities.

Who is eligible for this program?

An individual receiving hospital services or community member who does not have insurance coverage, but who, based on their self-reported income and circumstances, may be eligible for Medicaid coverage.

Presumptive Eligibility may only be applied to the following Medicaid categories:

- Children under Age 19 (PHC)
- Parents and Caretaker Relatives (PCR)
- Former Foster Care (FFC) Children to Age 26
- Breast and Cervical Cancer Treatment Program (BCCP)
- Healthy Connections Checkup*
- Pregnant Women (PW) **

* *Checkup category does not provide full Medicaid benefits.*
** *PW is limited to ambulatory prenatal care and does not include labor and delivery.*

Where can I find resources to help complete this application?

- Visit **scdhhs.gov** and read our Frequently Asked Questions.
- Call the Provider Service Center at (888) 289-0709 to speak to a representative.
- Check out this online resource: **http://medicaidelearning.com**.

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 1 Tell us about the individual.

PRESUMPTIVE ELIGIBILITY

All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1 **SELF**
2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female
4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.)	17. E-mail address (Leave blank if you don't have one)

18. Does the applicant need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is the applicant a resident of South Carolina? ☐ Yes ☐ No

20. Is the applicant a US citizen or US national? ☐ Yes ☐ No

a. If no, is the applicant a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ -___ ___ ___ ___

22. Is the applicant pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has the applicant been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was the applicant enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 2

Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include the individual's family members who live with the individual, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings. All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1

2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.)	17. E-mail address (Leave blank if you don't have one.)

18. Does this person need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is this person a resident of South Carolina? ☐ Yes ☐ No

20. Is this person a US citizen or US national? ☐ Yes ☐ No

a. If no, is this person a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

22. Is the person pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has this person been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was this person enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 3

Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include the individual's family members who live with the individual, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings. All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1

2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.)	17. E-mail address (Leave blank if you don't have one.)

18. Does this person need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is this person a resident of South Carolina? ☐ Yes ☐ No

20. Is this person a US citizen or US national? ☐ Yes ☐ No

a. If no, is this person a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

22. Is the person pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has this person been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was this person enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 4

Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include the individual's family members who live with the individual, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings. All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix	Relationship to PERSON 1

2. Date of birth (mm/dd/yyyy)	3. Sex: ☐ Male ☐ Female

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code	9. County

10. Mailing address (if different from home address)	11. Apartment or suite number

12. City	13. State	14. ZIP code	15. County

16. Phone number (Leave blank if you don't have one.)	17. E-mail address (Leave blank if you don't have one.)

18. Does this person need health coverage? If "No", go to question 26. ☐ Yes ☐ No

19. Is this person a resident of South Carolina? ☐ Yes ☐ No

20. Is this person a US citizen or US national? ☐ Yes ☐ No

a. If no, is this person a qualified alien? ☐ Yes ☐ No

21. Social Security Number (Optional): ___ ___ ___ - ___ ___ -___ ___ ___ ___

22. Is the person pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

23. Is this person a parent or caretaker relative? ☐ Yes ☐ No

24. Has this person been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

25. Was this person enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

26. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

If you have more people to add, complete this form for each additional person.

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 2 Sign this application

PRESUMPTIVE ELIGIBILITY

▶ Signature of applicant/individual listed in Step 1 (Optional)	Date (mm/dd/yyyy)

STEP 3 Return the completed application.

PRESUMPTIVE ELIGIBILITY

Mail your signed application to:

SCDHHS
PO Box 100101
Columbia SC 29202-3101

–OR–

Fax your signed application to:

(803) 255-8253

If you want to register to vote, you can complete a voter registration form at **scvotes.org**.