Medicaid Presumptive Eligibility



PRIORITY PROCESSINGThis is not a full Medicaid application



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 <u>scdhhs.gov</u> 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.

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Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html

STEP 1: PERSON 1 Tell us about the individual.

PRESUMPTIVE ELIGIBILITY

All fields on this form are required unless noted as optional. 2. Relationship to PERSON 1 1. First name, middle name, last name and suffix **SELF** 3. Date of birth (mm/dd/yyyy) 5. Social Security Number (Optional) 4. Sex: Male Female 6. Home address (Leave blank if you don't have one.) 7. Apartment or suite number 8. City 9. State 10. ZIP code 11. County 12. Mailing address (if different from home address) 13. Apartment or suite number 14. City 16. ZIP code 15. State 17. County 18. Phone number (Leave blank if you don't have one.) 19. E-mail address (Leave blank if you don't have one) Yes No 20. Does the applicant need health coverage? If "No", go to question 28. Yes □No 21. Do you want to apply for Family Planning benefits? Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning. □No 22. Is the applicant a resident of South Carolina? No 23. a.Is the applicant a US citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) \square Yes b.ls the applicant a US national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) \Box Yes | |Yes No c. If no, is the applicant a qualified alien? Yes No 24. Is the applicant pregnant? 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. 25. Is this person a parent or caretaker relative? Yes No. Yes No 26. Has the applicant been diagnosed with / receiving treatment for any of the following? • Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3) ___Yes No 27. Was the applicant enrolled in Medicaid and in foster care in South Carolina at age 18 or older? 28. 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. How often? (check one) \square Weekly \square Biweekly \square Monthly \square Yearly Amount \$ 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. How often? (check one) Weekly Biweekly Monthly Yearly Amount \$

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STEP 1: PERSON 2 Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include family members who live with the, 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.

	94 24. 42552124 4.5 94					
1. First name, middle name, last name and suffix				2. Relationship to PERSON 1		
3. Date of birth (mm/dd/yyyy)	4. Sex: Male Female	5. Social Security Number (Optional)				
6. Home address (Leave blank if you don't have one.)				7. Apartment or suite number		
8. City		9. State	10. ZIP code	11. County		
12. Mailing address (if different from home address)				13. Apartment or suite number		
14. City		15. State	16. ZIP code	17. County		
18. Phone number (Leave blanl	k if you don't have one.)	19. E-mail add	dress (Leave blank	 if you don't have o	ne)	
20. Does the applicant need he		question 28.			☐ Yes ☐ Yes	□ No
Family Planning is a limited beneservices and certain limited prev question blank, we will not asses	efit program, which provides for entative screenings. Family Pla	amily planning anning is not fu	services, family plar ll Medicaid coverage	nning-related c. If you leave this		
22. Is the applicant a resident					□Yes	□No
23. a.ls the applicant a US citize		citizen: or form	er alien now natura	lized as a LLS citize		□No
b.Is the applicant a US nationa						□No
c. If no, is the applicant a quali		s. remitory wild	elects to be a flation	iai, fiot a 0.3. citize	Yes	□No
24. Is the applicant pregnant?				Yes	□No	
,, ,	are expected? b. \	What is the du	e date?			
Note: PE coverage for pregna Healthy Connections will follow t	nt women is limited to ambuld up with the individual to apply	atory prenatal c for further cov	are. It does not cove erage.	er labor and deliver	у.	
25. Is this person a parent or c	aretaker relative?	\square No				
26. Has the applicant been diagnosed with / receiving treatment for any of the following?				Yes	□No	
Breast Cancer	Cancer • Atypical Breast Hyp	perplasia • Pre	ecancerous Cervica	l Lesion (CIN 2/3)		
27. Was the applicant enrolled			_		Yes	□No
28. INCOME (Write the total inc		-		nk.		
	e, wages, salaries, and self-em	_				
Amount \$	•	-	Veekly L Biweek	,	•	
Administration (SSDI). I	nple, unemployment checks, Do not include Supplementa	Security Incor	ne (SSI) or any chil	d support you rece	eive.	
Amount \$	How often? (che	eck one) \square v	Veekly Biweek	dv 🗌 Monthly	Yearly	

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STEP 1: PERSON 3 Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include family members who live with the, 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.

All fields of trils form are required utiless noted as	орионаі.				
1. First name, middle name, last name and suffix			2. Relationship to PERSON 1		
3. Date of birth (mm/dd/yyyy) 4. Sex: Male Fem	ale 5. Social Sec	onal)			
6. Home address (Leave blank if you don't have one.)			7. Apartment or suite number		
8. City	9. State	10. ZIP code	11. County		
12. Mailing address (if different from home address)			13. Apartment or suite nu	mber	
14. City	15. State	16. ZIP code	17. County		
18. Phone number (Leave blank if you don't have one.)	19. E-mail ad	19. E-mail address (Leave blank if you don't have one)			
20. Does the applicant need health coverage? If "No", go 21. Do you want to apply for Family Planning benefits? Family Planning is a limited benefit program, which provid services and certain limited preventative screenings. Family question blank, we will not assess you for Family Planning. 22. Is the applicant a resident of South Carolina? 23. a.ls the applicant a US citizen? (Born in U.S.; child of U.S.) the applicant a US national? (Born in unincorporated c. If no, is the applicant a qualified alien?	es family planning / Planning is not fu J.S. citizen; or form	ull Medicaid coverage	e. If you leave this Yes lized as a U.S. citizen)	□ No	
24. Is the applicant pregnant? a. If yes, how many babies are expected?	b. What is the du	ue date?	Yes	□No	
Note: PE coverage for pregnant women is limited to am Healthy Connections will follow up with the individual to ap		care. It does not cov verage.	er labor and delivery.		
 26. Has the applicant been diagnosed with / receiving to • Breast Cancer • Cervical Cancer • Atypical Breast 27. Was the applicant enrolled in Medicaid and in foster 	Hyperplasia • Pr	ecancerous Cervica rolina at age 18 or	older?	□ No	
28. INCOME (Write the total income before taxes are ta	-		nk.		
▼ Job income For example, wages, salaries, and self					
	•	•	kly		
 Other income For example, unemployment che Administration (SSDI). Do not include Suppleme 	cks, allmony, or d ntal Security Inco	me (SSI) or any chil	d support you receive.		
Amount \$ How often?	(check one)	Weekly \square Biweek	kly \square Monthly \square Yearly		

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STEP 1: PERSON 4 Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include family members who live with the, 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.

1. First name, middle name, last name and suffix			2. Relationship to PERSON 1			
3. Date of birth (mm/dd/yyyy)	4. Sex: Male Female	5. Social Sec	urity Number (Optio	onal)		
6. Home address (Leave blank if you don't have one.)				7. Apartment or suite number		
8. City		9. State	10. ZIP code	11. County		
12. Mailing address (if different from home address)				13. Apartment or suite number		
14. City		15. State	16. ZIP code	17. County		
18. Phone number (Leave blank	c if you don't have one.)	19. E-mail ad	dress (Leave blank	if you don't have one)		
20. Does the applicant need he	ealth coverage? If "No", go to	question 28.		Yes	□No	
21. Do you want to apply for Fa	amily Planning benefits?			□Yes	\square No	
Family Planning is a limited beneservices and certain limited prev question blank, we will not asses	entative screenings. Family Pl	amily planning anning is not fu	services, family plan Ill Medicaid coverage	nning-related c. If you leave this		
22. Is the applicant a resident of South Carolina?			☐Yes	\square No		
23. a.ls the applicant a US citize	en? (Born in U.S.; child of U.S.	citizen; or form	ner alien now natural	ized as a U.S. citizen)	□No	
b.Is the applicant a US national	l? (Born in unincorporated U.S	S. Territory who	elects to be a nation	nal, not a U.S. citizen) Yes	\square No	
c. If no, is the applicant a qualified alien?				□Yes	□No	
24. Is the applicant pregnant?				□Yes	□No	
a. If yes, how many babies	are expected?b.	What is the du	ie date?			
Note: PE coverage for pregna Healthy Connections will follow to	nt women is limited to ambuloup with the individual to apply	atory prenatal for further cou	care. It does not cove verage.	er labor and delivery.		
25. Is this person a parent or co	aretaker relative?	□No				
26. Has the applicant been diag			of the following?	□Yes	□No	
	Cancer • Atypical Breast Hy	_	_			
27. Was the applicant enrolled	3,	•			□No	
28. INCOME (Write the total inc			_			
▼ Job income For example	e, wages, salaries, and self-em	ployment inco	me.			
Amount \$	How often? (ch	eck one) 🔲 '	Weekly \square Biweek	dy \square Monthly \square Yearly		
	nple, unemployment checks Do not include Supplementa		-	• • •		
Amount \$	How often? (ch	eck one)	Weekly \square Biweek	dy \square Monthly \square Yearly		
lf you ha	ve more people to add, co	mplete this fo	orm for each addit	ional person.		

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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:

Fax your signed application to:

SCDHHS PO Box 100101 Columbia SC 29202-3101 (803) 255-8253

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

-OR-

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