

# **DMA ADMINISTRATIVE LETTER NO: 03-18, HOSPITAL PROVIDER INSTRUCTIONS FOR DETERMINING PRESUMPTIVE ELIGIBILITY**

**DATE:** July 1, 2018

**SUBJECT:** Hospital Provider Instructions for Determining Presumptive Eligibility

**DISTRIBUTION:** Qualified Presumptive Eligibility Hospitals  
County Directors of Social Services  
Medicaid Eligibility Staff

## **I. BACKGROUND**

The purpose of this administrative letter is to provide procedures for Qualified Medical Providers (QMPs) hospitals to determine Presumptive Eligibility (PE). DMA Administrative Letter NO: 11-13, is obsolete with the issuance of this letter.

A qualified medical provider is a hospital that is authorized to make presumptive eligibility determinations based on preliminary information, according to policies and procedures established by the North Carolina Division of Medical Assistance (DMA).

## **II. HOSPITAL ENROLLMENT PROCESS**

**A. Hospitals that elect to make presumptive eligibility determinations may contact the Department of Health Human Services (DHHS)/DMA Provider Services by:**

1. Phone at (919) 855-4050, or
2. Written request faxed to (919) 715-8548, or
3. Mailing a written request to: DHHS/DMA Provider Services, 2501 Mail Service Center, Raleigh, NC 27699.

**B. Provider Services will forward the Presumptive Eligibility Determination Provider Agreement packet to the hospital for completion.**

**C. The hospital must:**

1. Complete all required training regarding the Presumptive Eligibility policy and procedures, and
2. Sign the Provider Agreement, and
3. Provide attestation of training, and
4. Identify all staff authorized to determine presumptive eligibility, and
5. Provide each staff member's business North Carolina Identity Management (NCID) for NCFast portal access. To request a business NCID go to <https://ncid.nc.gov>, and
6. Report all changes in staff authorized to determine Presumptive Eligibility to DMA within 10 days of the change.

All documents should be returned to DMA at the address in II.A.3 above.

**D. DMA may authorize the hospital to complete presumptive eligibility determinations upon completion of the requirements in II.C. 1-5 above.**

**III. A QUALIFIED MEDICAL PROVIDER IS A HOSPITAL THAT:**

- A. Participates as a provider under the state plan,**
- B. Notifies DMA of its election to make presumptive eligibility determinations,**
- C. Agrees to make presumptive eligibility determinations consistent with state policies and procedures,**
- D. Has not been disqualified as a QMP by DMA,**
- E. Does not delegate or contract out presumptive eligibility determination to a third party or other entity,**
- F. Does not serve as authorized representative of any individual applying for presumptive eligibility,**
- G. Meets performance measures**

#### **IV. HOSPITAL COMPLIANCE PROCEDURES:**

##### **A. The hospital must:**

1. Meet performance measures established by DMA within six (6) consecutive months or for any subsequent six-month period after the approval of the PE by Hospitals Agreement:
  - a. 95% of the PE approvals submit a regular Medicaid application.
  - b. 95% of the individuals determined eligible for PE, who submit a regular Medicaid application are subsequently approved for regular Medicaid.
2. Correctly determine presumptive eligibility.

##### **B. When performance measures are not met, the hospital must:**

1. Complete one additional DMA approved training on presumptive Medicaid eligibility determination within 10 business days of the date of DMA notice that the hospital is not in compliance with the Presumptive Eligibility Standards, and
2. Implement a corrective action plan when prescribed by DMA, and
3. Improve its performance by meeting standards within three months after completing an additional training and implementing an approved corrective action plan, if required.

##### **C. The hospital shall maintain a three (3) year retention record of all presumptive eligibility determinations and provide DMA access to the records for performance monitoring.**

#### **V. MEDICAID APPLICANT FINANCIAL AND NON-FINANCIAL ELIGIBILITY REQUIREMENTS**

##### **A. To be authorized presumptively, an applicant must:**

1. Attest to U.S. citizenship, U.S. national, or satisfactory immigration status.
2. Attest to North Carolina residency or intent to reside in North Carolina.

3. Not be an inmate of a public institution.
4. Not be receiving Medicaid in another aid/program category, county, or state.
5. Have gross income equal to or less than the income limit for the individual's applicable Medicaid group.

**B. The presumptive period is limited to:**

1. Once per pregnancy for Medicaid for Pregnant Women (MPW).
2. Once in a two-year period for all other eligible programs.

Example: Individual is determined presumptively eligible on January 5, 2018. The individual may not be determined presumptively eligible again until January 5, 2020.

**VI. QUALIFYING GROUPS FOR PRESUMPTIVE ELIGIBILITY**

Eligibility for the following groups is based on Modified Adjusted Gross Income (MAGI) and there is no resource test. See current MAGI income limit chart. The income limit chart changes yearly effective April 1<sup>st</sup> and can be located on the DMA website under [Hospital Presumptive Training](#), along with other training materials.

**A. Pregnant Women (MPW)**

To qualify for presumptive MPW, the applicant must:

1. Be a pregnant female (any age),
2. Attest to pregnancy,
3. Have income equal to or less than 196% of the Medicaid income limit based on family size, and
4. Meet all other non-financial eligibility requirements specified in V. above.

Covered services are limited to ambulatory prenatal services only.

## **B. Medicaid for Infants and Children (MIC)**

To qualify for presumptive MIC, the child must:

1. Be under age 19,
2. Have income equal to or less than the Medicaid income limit for the child's age group and family size, and
3. Meet all other non-financial eligibility requirements specified in section V. above.

Covered services include professional medical services including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

## **C. Medicaid for Families with Dependent Children (MAF-C/N)**

To qualify for presumptive MAF, the applicant must:

1. Be an individual under age 21, or
2. Be a parent/caretaker relative who lives in the home with a child under age 18 and provides the child's day to day care and supervision. The caretaker cannot be incarcerated. Relative is defined as an adult who is related to the dependent child by blood, adoption, or marriage. Refer to the Integrated Eligibility Manual (IEM), section [15034](#). Examples are:
  - a. Natural, adoptive, stepparent, or marriage to the parent/caretaker
  - b. Grandparent
  - c. Siblings, including step-brothers and sisters
  - d. Aunt/Uncle
  - e. First cousin
  - f. Nephew/Niece
3. Have income equal to or less than the Medicaid income limit based on family size, and

4. Meet all other non-financial eligibility requirements specified in section V. above.

Covered services include professional medical services including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

#### **D. Family Planning Program (MAF-D)**

To qualify for presumptive MAF-D, the applicant must:

1. Have income equal to or less than 195% Medicaid income limit based on family size, and
2. Meet all other non-financial eligibility requirements specified in section V. above.

Note: There is no age restrictions for a MAF-D applicant.

Covered services include only family planning services, consultation, examination, treatment, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception. Each service may have certain limitations, including the need for prior approval.

#### **E. Former Foster Care Children (MFC)**

To qualify for presumptive MFC, the applicant must:

1. Be an individual age 18 up to age 26, and
2. Have been enrolled in North Carolina foster care and received North Carolina Medicaid when the individual turned age 18, and
3. Meet all other non-financial eligibility requirements specified in section V. above. There is no income test.

Covered services include professional medical services including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

## **F. Breast & Cervical Cancer Medicaid (BCCM)**

Hospitals authorized through the Breast and Cervical Cancer Control Program (BCCCP) are eligible to determine presumptive eligibility for BCCM.

To qualify for presumptive BCCM, the individual must:

1. Be a woman under age 65, and
2. Be screened for breast or cervical cancer through a BCCCP, have income at or below 250% of the current Federal Poverty Level, and be found to need treatment for breast or cervical cancer, and
3. Not have any creditable medical insurance coverage including Medicaid and/or Medicare, and
4. Meet all other non-financial eligibility requirements specified in section V. above.

Covered services include professional medical services, including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

## **VII. HOSPITAL INSTRUCTIONS FOR DETERMINING ELIGIBILITY**

### **A. Conduct an interview**

Complete the [DMA-5032\(H\)](#), Presumptive Eligibility Determination by Hospital:

1. Ask the individual if they have a current Medicaid case or pending Medicaid application:
  - a. If pending application exists, a presumptive application may be completed.
  - b. If determined presumptively eligible, coverage can continue until the Medicaid determination is completed by the local county agency.

2. Verify whether the individual is currently receiving Medicaid in the Medicaid Management Information System (NCTracks):
  - a. If Medicaid case is active, an application should not be completed. Refer the individual to the local county agency to report change.
  - b. If no active Medicaid case exists, a presumptive application may be completed.
3. When interviewing the applicant about family size income, it is important to obtain accurate and complete information. Ask open-ended questions, such as:
  - a. Where do you work?
  - b. Where does your spouse work?
  - c. Do you expect to file taxes?
  - d. Do you expect to be claimed as a tax dependent?
  - e. How do you get money to pay your bills?
  - f. Who helps you pay your bills?
  - g. Do you or your spouse receive Social Security or other government payments?
  - h. Do you or your spouse receive unemployment benefits?

## **B. Establish Medicaid household and family size**

1. The Medicaid household is called the “Modified Adjusted Gross Income (MAGI) Household”. The MAGI household is determined based on whether the individual is a tax filer, tax dependent, or a non-tax filer. Each household member will have their own MAGI household.

Refer to the IEM, section [13030](#), Household Composition for MAGI household construction and the MAGI household composition chart.



- The family size is the number of individuals in the MAGI household. The number in the family size will determine what income limit is used for Medicaid eligibility.

**C. Determine total countable income for each MAGI household.**

- Counting income depends on the type of household (tax or non-filer) and which individual is involved. See chart below.

**MAGI ~ Household Composition**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Will applicant/ beneficiary file Taxes?  <b>Yes</b>	Will applicant/ beneficiary file Taxes?  <b>No</b>	Will applicant/ beneficiary file Taxes?  <b>Yes</b>	Will applicant/ beneficiary file Taxes?  <b>No</b>	Will applicant/ beneficiary file Taxes?  <b>No</b>	Will applicant/ beneficiary file Taxes?  <b>Yes</b>
Will applicant/ beneficiary be a tax <b>dependent</b> for anyone else?  <b>No</b>	Will applicant/ beneficiary be a tax <b>dependent</b> for anyone else?  <b>Yes</b>	Will applicant/ beneficiary be a tax <b>dependent</b> for anyone else?  <b>Yes</b>	Will applicant/ beneficiary be a tax <b>dependent</b> for anyone else?  <b>No</b>	Will applicant/ beneficiary be a tax <b>dependent</b> for anyone else?  <b>Yes</b>	Will applicant/ Beneficiary be a tax <b>dependent</b> for anyone else?  <b>Yes</b>
	Does the applicant/ beneficiary meet any of the <b>exceptions</b> *?  <b>No</b>	Does the applicant/ beneficiary meet any of the <b>exceptions</b> *?  <b>No</b>		Does the applicant/ beneficiary meet any of the <b>exceptions</b> *?  <b>Yes</b>	Does the applicant/ beneficiary meet any of the <b>exceptions</b> *?  <b>Yes</b>
<b>↓</b>	<b>↓</b>	<b>↓</b>	<b>↓</b>	<b>↓</b>	<b>↓</b>
<b>Tax HH:</b> HH is applicant, co-filer spouse and a/b's tax dependents. Include live in spouse if not included in tax HH.	<b>Tax HH:</b> HH is tax filer's household claiming a/b as a dependent. Include a/b's live-in spouse if not included in tax HH.		<b>Non-Filer HH:</b> HH is applicant/beneficiary, spouse in the home, and their children in home under age 19. <b>If applicant/beneficiary is under age 19:</b> Also includes: live-in parent(s) and live-in siblings under age 19		

**\*EXCEPTIONS:** Is the applicant/beneficiary:

1. A tax dependent of someone other than spouse or parent?
2. Under age 19 and living with both parents who will **not** file jointly?
3. Under age 19 and will be claimed by a non-custodial parent?

#### **Types of Medicaid/NCHC MAGI Households**

**Tax Household** – Used as Medicaid/NCHC when applicant/beneficiary is tax filer or tax dependent and no exceptions apply. The household includes:

- Tax Filer(s)
- Tax Dependents of Tax Filer(s)
- Spouse of applicant/beneficiary, if in the home and not in the tax household

**Non-filer household** – Used when applicant/beneficiary is not tax filer or tax dependent or meets one of the exceptions. The household includes:

- Individual, and if living in the home:
- Individual's spouse
- Individual's natural, adoptive and step children under age 19

If individual is under age 19, includes same as above AND

- Individual's natural, adoptive and step parent(s) in the home
- Individual's natural, adoptive and step siblings in the home under age 19

#### **Pregnant Women**

**NOTE:** Under either type of household (tax or non-filer), when a pregnant woman is the applicant/beneficiary, always include the unborn(s) in her household when determining her eligibility for any MAGI program. When the pregnant woman is a household member of another applicant/beneficiary, include only the PW – do not add the unborn(s).

## 2. What income is counted

Once the Medicaid household composition is established, determine the total gross countable income for each household.

### a. Countable Income

Countable income includes income such as, but not limited to:

- (1) Wages/tips
- (2) Unemployment benefits
- (3) Pensions and annuities
- (4) Military retirement/pension (Do not count veteran's benefits)
- (5) Income from business or personal services
- (6) Interest
- (7) Alimony received
- (8) Social Security benefits (RSDI)
- (9) Foreign earnings excluded from taxes
- (10) Lump sums in the month received
- (11) Self-Employment
  - Accept client's statement regarding business related expenses. Total countable income is the

total amount after deducting expenses from the gross countable income.

b. Non-Countable Income

Do not count the following income:

- (1) Child support
- (2) Veteran's benefits (Count military retirement/pension)
- (3) Supplemental Security Income (SSI)
- (4) Worker's Compensation
- (5) Gifts and inheritances
- (6) Scholarships, awards, or fellowship grants used for educational expenses. Any amount used for living expenses is countable income (room and board).
- (7) Lump sums, except in the month received
- (8) Certain Native American and Alaska Native income

c. Income Calculation

Convert the average income to a gross monthly amount.

- (1) If paid weekly, multiply by 4.3.
- (2) If paid biweekly, multiply by 2.15.
- (3) If paid semimonthly, multiply by 2.
- (4) If paid monthly, use the monthly gross.
- (5) If paid annually, divide by 12.

Example: Applicant receives income biweekly. On 9/7, she received \$218.75 gross and on 9/21, she received \$209.38 gross.

$\$218.75 + \$209.38 = \$428.13$ . Divide by 2 (number of pay periods received and used) =  $\$214.065$ , rounded to  $\$214.07$  (average income).

Convert to a monthly amount by multiplying  $\$214.07$  by 2.15 =  $\$460.2505$ , rounded to  $\$460.25$ . This is the gross monthly income.

## D. Determine eligibility

Compare the total countable income for each household member to the appropriate family size on the MAGI Medicaid Income Limits Chart.

1. If countable income for the household member is equal to or below the income limit for the appropriate family size, the individual is presumptively eligible.
2. If the countable income for the household member is greater than the income for the appropriate family size, the individual is presumptively ineligible.

## E. Examples

1. **Rose (48), Rose's daughter Alice, (17), and Alice's daughter, Kitty (1), are in the home. Rose claims Alice as a tax dependent. Kitty is claimed by her father, Dennis (20), who does not reside in the home.**

Family's financial situation:

**\$1560/monthly gross income-Rose's salary**  
**\$600/monthly - Child support payments received by Rose for Alice.**

### **Rose's countable income**

Monthly gross income \$1560.00

Rose's household consists of herself and her tax dependent, Alice. She has a family size of 2.

Rose is a tax household and she is the filer. Count the income of the tax filer and the income of any tax dependent who expect to file taxes. (Child support income received is not countable). Since Alice is not working and does not expect to file taxes, count only Rose's income.

Rose is potentially eligible for Family Planning Program Medicaid (MAF-D) as her income is under for a family size of 2. Her household income exceeds the income limit for a family size of 2 for Medicaid for Families with Dependent Children (MAF-C/N).

### **Alice's countable income**

Monthly gross income \$1560.00

Alice's household consists of herself and her mother, Rose. She has a family size of 2.

Alice is a tax dependent and a child of the tax filer. She does not meet any tax dependent exception. Her household and countable income is the same as her mother's countable income. Since Alice does not expect to file taxes, her income is not counted for herself or Rose.

Alice is eligible for MIC (6-18). Her income is below the income limit for a family size of 2.

**Kitty's countable income**

Monthly gross income \$0.00

Kitty is being claimed as a tax dependent by her father who does not live in the home. This means she is a tax dependent who meets an exception. She is claimed by a non-custodial parent.

Kitty's household consists of herself and her mother, Alice. She has a family size of 2.

Her mother does not have any countable income of her own. Rose is not included in Kitty's household so Rose's income is not countable to Kitty.

Kitty's countable income is \$0. She is eligible for MIC (0-5) as her income is below the income limit for a family size of 2.

	MAGI Household	Rose	Alice	Kitty	Family Size	Countable Income	Eligibility
Applicant	Rose	x	x		2	\$1560	MAF-D
	Alice	x	x		2	\$1560	MIC
	Kitty		x	x	2	\$0	MIC

- Sandy (45), her husband Ben (46), and their pregnant daughter, Samantha (17), are in the home. Sandy, Ben and Samantha do not expect to file taxes nor be claimed as tax dependents.**

Family financial situation

**\$1200.00/monthly gross income-Sandy's social security benefits**

**\$250.00/monthly gross income-Ben's veteran's benefits**  
**\$200.00/monthly gross income-Samantha's income from babysitting**

Veteran benefits are not counted.

**Sandy's countable income**

Monthly gross income \$1200.00

Sandy's household consists of herself, Ben, and Samantha. She has a family size of 3. Samantha is pregnant but the unborn child is not included when the pregnant woman is included in another person's household.

Sandy is a non-filer household. Count the income of the applicant, Sandy, her spouse Ben, and the income of any children in the household under age 19 who expect to file a tax return. Ben's only income is VA and is non-countable. Since Samantha does not expect to file a tax return, her income is not counted.

Sandy is potentially eligible for MAF-D because her income is below the income limit for a household of 3. Her income exceeds the MAF-C/N limit for a family size of 3.

Note: Sandy is potentially eligible for Adult Medicaid (ABD) if her Social Security income is disability or if she is over age 65. Her eligibility for ABD Medicaid will be determined once the full Medicaid application is submitted through ePASS. ABD is not a MAGI program and eligibility cannot be established through the presumptive process.

**Ben's countable income**

Monthly gross income \$1200.00

Ben's household consists of himself, Sandy, and Samantha. He has a family size of 3. Samantha is pregnant but the unborn child is not included when the pregnant woman is included in another person's household.

Ben is a non-filer household. Count the income of the applicant, Ben, his wife's income of \$1200 per month SSA, and the income of any children in the household under age 19 who expect to file a tax return. Ben's income is VA and it is not countable. Since Samantha does not expect to file a tax return, her income is not counted.

Ben is potentially eligible for MAF-D because his income is below the income limit for a household of 3. His income exceeds the MAF-C/N limit for a family size of 3.

**Samantha countable income**

Monthly gross income \$1200.00

Samantha’s household consists of herself, her unborn child, and her parents, Sandy and Ben. She has a family size of 4 because the unborn child is included in the household of the pregnant woman.

Samantha is a non-filer household. Count her parent’s income and the income of any children in the house under 19 who expect to files taxes. Sandy’s income is the only income that will count. Ben receives VA which is non-countable and Samantha does not expect to file taxes.

Samantha is eligible for MIC (6-18). Her income is below the income limit for a family size of 4.

Applicant	MAGI Household	Sandy	Ben	Samantha	Family Size	Household Income	Eligibility
	Sandy	x	x	x	3	\$1200	MAF-D
	Ben	x	x	x	3	\$1200	MAF-D
	Samantha	x	x	x+1	4	\$1200	MIC

- Mary (51), Mary’s son, Bill (22), Mary’s twin nephew and niece, Ned (10) and Nancy (10) are in the home. Mary claims all as tax dependents.**

Family financial situation:

**\$700.00/monthly gross income-Mary’s income from her home business after allowable self-employment tax deductions**  
**\$400.00/monthly gross income-Bill’s income from weekend jobs.**  
**\$500.00/monthly gross income- Ned’s SSA survivor’s benefits**  
**\$500.00/monthly gross income- Nancy’s SSA survivor’s benefits**

**Mary’s countable income**

Monthly gross income \$700.00

Mary's household consists of herself, Bill, Ned, and Nancy. She has a family size of 4.

Mary is a tax filer. Count the tax filer's income and the income of any tax dependents who expect to file taxes. Since Bill, Ned and Nancy are tax dependents and do not expect to file taxes, their income is not counted for Mary.

Mary is eligible for MAF-C/N because she is the caretaker of Ned and Nancy. Mary's income is below the income limit for a family size of 4.

**Bill's countable income**

Monthly gross income	\$700.00
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Bill's household consists of himself, Mary, Ned, and Nancy. He has a family size of 4.

Bill is a tax dependent and child of a tax filer. He does not meet any tax dependent exceptions. His countable income is the income of the tax filer and the income of any other tax dependent who expects to file taxes. None of the tax dependents, including Bill, expect to file taxes. His household and countable income is the same as his mother's countable income.

Bill is potentially eligible for MAF-D. His household income is below the income limit for a family size of 4. He does not qualify for MAF-C/N because he does not qualify as a caretaker and he is over the age of 20.

**Ned's countable income**

Monthly gross Ned	\$500.00
Monthly gross Nancy	\$500.00

Ned's household consists of himself and his sibling, Nancy. He has a family size of 2.

Mary claims Ned on her taxes, but Ned meets an exception because he is a tax dependent of someone other than a spouse or parent. Use non-filer rules for Ned. He is under age 19 and his parents are not in the home. Count his income and the income of his live-in siblings under age 19 regardless of whether they expect to file taxes.

Ned's countable income is his income of \$500 and his sister's income of \$500 per month. His total countable income is \$1000.00. Ned is



eligible for MIC (6-18). His income is below the income limit for a family size of 2.

**Nancy’s countable income**

Monthly gross Nancy               \$500  
 Monthly gross Ned                   \$500

Nancy’s household consists of herself and her sibling, Ned. She has a family size of 2.

Mary claims Nancy on her taxes, but Nancy meets an exception because she is a tax dependent of someone other than a spouse or parent. Use non-filer rules for Nancy. She is under age 19 and her parents are not in the home. Count her income and the income of her live-in siblings under age 19 regardless of whether they expect to file taxes.

Nancy’s countable income is her income of \$500 and her brother’s income of \$500 per month. Her total countable income is \$1000.00. Nancy is eligible for MIC (6-18). Her income is below the income limit for a family size of 2.

Applicant	MAGI Household	Mary	Bill	Ned	Nancy	Family Size	Countable Income	Eligibility
	Mary	x	x	x	x	4	\$700	MAF
	Bill	x	x	x	x	4	\$700	MAF-D
	Ned			x	x	2	\$1000	MIC
	Nancy			x	x	2	\$1000	MIC

**F. Provider instructions for approving eligibility**

1. Ensure the [DMA-5032\(H\)](#), Presumptive Eligibility Determination by Hospital form is completed, per the instructions on the back of the form.
2. If determined eligible for presumptive Medicaid submit the Medicaid application through NCFAST via [ePASS](#).
3. Provide the applicant one copy of the [DMA-5033](#) Hospital Presumptive Eligibility Transmittal form. Send original to the local agency in the county in which the applicant resides and retain one copy for your file.
4. The hospital must send the [DMA-5032\(H\)](#) to the local agency within five business days if the applicant is deemed presumptively eligible.

Send original to the local agency, one copy to the applicant, and retain one copy for your file.

5. The applicant should be encouraged to apply for other Medicaid programs through [ePASS](#), by phone or completing a face-to-face interview with a representative of the [Department of Social Services \(DSS\)](#), or print and mail, or fax a completed [Medicaid Application](#) to the local county agency where the individual resides.

#### **G. Provider instructions for denying eligibility**

1. Ensure the [DMA-5032\(H\)](#), Presumptive Eligibility Determination by Hospital form is completed, per the instructions on the back of the form.
2. If determined ineligible for presumptive Medicaid, complete the [DMA-5035/DMA5035sp](#), Presumptive Eligibility Denial form.
  - a. Give the original to the applicant and keep a copy for your file.
  - b. Document ineligibility on the [DMA-5032\(H\)](#) and file in your records with a copy of the denial form. Do not send a copy to the local agency.
3. The applicant should be encouraged to apply for other Medicaid programs through [ePASS](#), by phone or completing a face-to-face interview with a representative of the [Department of Social Services \(DSS\)](#), or print and mail, or fax a completed [Medicaid Application](#) to the local county agency where the individual resides.

#### **H. Presumptive eligibility period**

Eligibility begins on the day the presumptive eligibility is determined and application is signed and ends on the earliest of the following dates, depending upon whether a regular Medicaid application is made:

1. If no regular Medicaid application is made, coverage ends on the last day of the month following the month presumptive eligibility was determined.
2. If a regular Medicaid application is made, coverage ends on the day the local county agency makes an eligibility determination on the regular Medicaid application.

## VIII. APPEAL RIGHTS

There are no appeal rights for presumptive eligibility

If you have any questions regarding this information, please contact Eligibility Services.

Sincerely,

A handwritten signature in black ink, appearing to read "Dave Richard". The signature is stylized with a large initial "D" and "R".

Dave Richard  
Deputy Secretary for Medical Assistance

(This material was researched and written by Rachel Keels, Policy Consultant, Medicaid Eligibility Unit).