

**NOTICE OF DECISION ON YOUR PRESUMPTIVE MEDICAID ELIGIBILITY  
APPLICATION FOR HOME HEALTH OR COMMUNITY HOSPICE CARE SERVICES**

<b>NOTICE</b> <b>DATE:</b>		NAME AND ADDRESS OF AGENCY/CEI		
CASE NUMBER		CIN/RID NUMBER		
CASE NAME (And C/O Name if Present) AND ADDRESS				
+---+		---+	<b>GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP</b>	
+--		---+		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

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

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 +-+ ACCEPT your presumptive Medicaid eligibility application 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.

Your total unverified monthly income is \$\_\_\_\_\_. The difference between your net income and the Medicaid level is \$\_\_\_\_\_. This is called your monthly surplus income. Each month, Medicaid will pay medical expenses above this figure that are incurred during the month. This figure will be adjusted as necessary to the extent that your verified income is higher or lower than you have indicated.

In addition to any income contribution, \$\_\_\_\_\_ of excess resources must be contributed toward the cost of care from \_\_\_\_\_ to \_\_\_\_\_.

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.