PRESUMPTIVE ELIGIBILITY PREGNANCY
Patient Information Form

Social Security Number ________________ ☐ This person does not have a social security number

Name: ____

Last Name First Name Middle Initial

Date of Birth: ____________________ Age __________ ☐ Female

Marital Status (check one): ☐ Single-Never Married ☐ Divorced ☐ Separated ☐ Legally Separated

☐ Widowed ☐ Living Together Partner ☐ Married Living Together ☐ Married Living Apart

- Has this person received Presumptive Eligibility benefits for this pregnancy? ☐ Yes ☐ No
- Is this person a resident of Kentucky? ☐ Yes ☐ No
- Is this person a US citizen? ☐ Yes ☐ No
- Race: ____________________ Nationality: ________________
- Is this person of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No
- Ethnicity: ____________________
- Preferred Written Language ☐ English ☐ Spanish
- Would this person like to be referred for WIC? ☐ Yes ☐ No
- Is this person currently incarcerated? ☐ Yes ☐ No
- If yes, when did this person enter prison? (mm/dd/yyyy) ________________
- What date should benefits begin? ______________________

Address:

____

Street Address Apt/Building Number

____

City State Zip Code

____

County

Telephone Number(s):

____

Home/Cell Telephone Number Work Telephone Number other

How many family members does this person have? ______________

When calculating family size, include the expectant mother, any unborn child/children, dependent children living in the home, and spouse. If the expectant mother is living with parents and under age 19, count the parents, step-parent, and siblings under 19 in the household size.

Expected due date (mm/dd/yyyy) ______________________________________

FAMILY INCOME

	Family Member's Name	Income Type*	How Much? **	How Often
1				
2				
3				
4				
	TOTAL MONTHLY INCOME:			

Count the income of the expectant mother, spouse, and parents' income (if the expectant mother is living with parents and claimed as a tax dependent). Include gross wages (before taxes) and other sources of income such as social security, pensions, alimony, and annuities.

Do not count child support or SSI (Supplemental Security Income).

Do not count income of dependent children (whether or not they live in the home with the expectant mother).

OTHER INSURANCE

Does this person currently have insurance that covers doctors, office visits, and hospitalization?

☐ Yes ☐ No

If "Yes" what is the name of this plan ________________________

Name of Insurance Co. Policy No. Group No.

____

Primary Care Physician ____

I certify, under penalty of perjury, the information provided by me in this statement is correct and true to the best of my knowledge. I understand that anyone who gives false information in order to receive benefits or lets someone else use their PE card or abuses PE benefits is subject to criminal action under federal law, state law, or both or may be liable for repaying in cash the value of the benefits received.

__________________________ ____________

Patient Signature Date Signed