

**PRESUMPTIVE ELIGIBILITY HOSPITAL**  
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 \_\_\_\_\_  Male  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 this calendar year?  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
- Is this person currently pregnant?  Yes  No
- If yes, how many children is this person expecting from this pregnancy? \_\_\_\_\_
- What is the due date? (mm/dd/yyyy) \_\_\_\_\_
- Has this person received Presumptive Eligibility for this pregnancy?  Yes  No
- 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) \_\_\_\_\_
- Is this person a parent caretaker for any child in the household?  Yes  No
- Has this person ever been in foster care?  Yes  No If yes, what state? \_\_\_\_\_
- Did this person get healthcare through this state's Medicaid program?  Yes  No
- How old was this person when he/she left the foster care system? \_\_\_\_\_

• 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 patient, any unborn child/children, dependent children and spouse. If patient is living with parents and under age 19, count parents, step-parent and siblings under 19 in the household size.

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**FAMILY INCOME**

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

*Count income of the patient, spouse and parents' income (if the patient 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, cash gifts, 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).*

**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.

**Preferred MCO:**

Anthem Blue Cross/Blue Shield  CoventryCares  Humana CareSource  
 Passport Health Plan  WellCare  
 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