



PRESUMPTIVE ELIGIBILITY (PE) APPLICATION ONLY

This application is used for Presumptive Eligibility (PE) determinations for:

- Children (HMK *Plus* and HMK)
- Former Foster Care Children, ages 18 up to 26
- Parent/Caretaker Relative Medicaid
- Pregnant Woman
- Breast & Cervical Cancer

For ongoing coverage, applicants may:

- Apply online at www.healthcare.gov; or phone 1-800-318-2596
- Apply online at www.apply.mt.gov or phone 1-888-706-1535
- Apply by mail using a paper ***Application for Health Coverage***.
Mail application to: P.O. Box 202925, Helena, MT 59620-2925

Applicant Information - Please PRINT CLEARLY.

| | |
|---------------------------------|-----------------|
| First/Last Name: | |
| Home Address: | City/State/ZIP: |
| Mailing Address (if Different): | City/State/ZIP: |
| Home or Cell Phone: | Message Phone: |

Household Information -- Complete for every person living in the household. List adults first, then children. Social Security Numbers are requested but are not required. *U.S. Citizenship and *Qualified Non-Citizen status **ONLY** need to be included for persons applying for Presumptive Eligibility. ****Answer ONLY for HMK.**

| Name (First – Middle Initial – Last) | Relationship to Applicant | Apply for PE? (Y/N) | Social Security Number | Date of Birth (mm/dd/yyyy) | Gender (M/F) | *U.S. Citizen (Y/N) | SEE PAGE 3 ADDENDUM *Qualified Non-Citizen (Y/N) | Montana Resident (Y/N) | **Has Health Insurance (Y/N) |
|---|---------------------------|------------------------|------------------------|-------------------------------|-----------------|------------------------|---|---------------------------|---------------------------------|
| 1 | (self) | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |

Is anyone in the household pregnant? ___ Yes ___ No **If "Yes", who?** _____ Date Due _____ How many unborns? _____

Was anyone in Foster Care and receiving Medicaid at age 18? ___ Yes ___ No **If "Yes", who?** _____

Applicant: Please also complete **Household Income Information** and **Signature** on Next Page.

Household Income Information and Applicant Signature

Earned Income -- List this MONTH'S total gross wages before taxes for each person; **Unearned Income** -- List all monthly unearned income (i.e., Unemployment, Social Security, Pensions, Interest/Dividends) for each person. (Do not include Child Support or Worker's Comp)

| First Name | Earned Income Total | Unearned Income Total | TOTAL (Monthly Gross) |
|------------|---------------------|-----------------------|--------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

COMBINED TOTAL MONTHLY GROSS INCOME = \$ _____

(Applicant OR Parent/Guardian/Other) – I understand the questions on this application and the penalty for withholding or giving false information. I certify, under penalty of perjury, all my answers are correct and complete to the best of my knowledge. I understand the information provided on this application can be used to establish identity for children under age 16.

Applicant Name _____ Applicant Signature _____
(Please Print)

(Presumptive Eligibility may last 60 days or less and is limited to once every 365 days OR once/pregnancy).

FOR OFFICE USE ONLY – Qualified Entity must complete all information below:

COMBINED TOTAL MONTHLY GROSS INCOME for Household: \$ _____ ** Household Size _____

(**Compare this amount to the Income Calculation Tool for the appropriate category of applicant(s) based on household size, then finalize determination).

DATE DETERMINED (mm/dd/yyyy) _____ Facility _____

QE Signature _____

QE Name (print) _____

QE Phone _____ QE FAX _____ QE Email _____

Within 5 days of Determination, SCAN application and Proof of Temporary Coverage form, then create a secure ePass account at transfer.mt.gov, and email scanned documents to: HHSPresumptive@mt.gov – OR FAX same documents to: 1-877-418-4533.

Presumptive Eligibility Application Addendum for Qualified Non-Citizens

ALL PERSONS WHO ARE IMMIGRANTS NEED TO REVIEW THE FOLLOWING INFORMATION TO DETERMINE IF THEY ARE A QUALIFIED NON-CITIZEN; THEN THEY SHOULD MARK THE APPROPRIATE RESPONSE ON PAGE 1.

Those who are in ANY of the following groups would be considered a Qualified Non-Citizen:

- Lawful Permanent Residents (LPR/Green Card Holder)** -- SEE FURTHER INFORMATION, BELOW
- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Children lawfully residing in the state of Montana (lawfully present and otherwise eligible for Medicaid or HMK in the state, including being a state resident)

****In order to get Medicaid coverage, under current law most ADULT Lawful Permanent Residents or green card holders have a 5-year waiting period. This means they must wait 5 years after receiving “qualified” immigration status before being eligible for Medicaid. There are also exceptions -- Lawful Permanent Residents who don’t have to wait 5 years -- such as people who used to be refugees or asylees.**

Montana has removed the 5-year waiting period to cover lawfully residing children who are otherwise eligible for Medicaid or HMK. A child is “lawfully residing” if lawfully present and otherwise eligible for Medicaid or HMK in the state (including being a state resident).

NOTE: Immigrants who are qualified non-citizens are generally eligible for Medicaid and Children’s Health Insurance Program (HMK) coverage IF they are otherwise eligible for Medicaid and HMK in the state; that is, if they meet Montana’s income eligibility rules.