DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

PRESUMPTIVE ELIGIBILITY (PE) APPLICATION

Introduction

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
- Individuals between the ages of 19-64

For ongoing coverage, applicants may:

- 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 to: P.O. Box 202925, Helena, MT 59620-2925

Applicant Information – Please Print Clearly

First Name:	**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. SSN requested but not required. *U.S. Citizenship and *Qualified Non-Citizen status ONLY need to be included for persons applying for PE. **Answer ONLY for HMK

Name (First-MI-Last)	Relationship to Applicant	Apply for PE? (Y/N)	Social Security #	Date of Birth (MM/DD/YYYY)	Gender (M/F)	U.S. Citizen (Y/N)*	Qual. Non-Citizen (Y/N)*	Montana Resident (Y/N)	Has Health Insurance (Y/N)**

Is anyone in the household pregnant? ☐Yes ☒ No If "Yes", who? _____ Due Date _____ Unborns _____

Was anyone in foster care and receiving Medicaid at age 18? ■ Yes ☐ No If "Yes", who?_____

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)

Name	Earned Income Total	Unearned Income Total	Total (Monthly Gross)
		Combined Monthly Gross Income	

Community Engagement (CE) Requirements Attestation and Applicant Signature

This section should only be completed for individuals aged 19-64 with a household income at or under the Affordable Care Act (ACA) adult income limit for their household size.

CE Exclusion Attestation Statement (if applicable) – Check the exclusions that apply to you at the time of application.

I, _____, confirm that (check one or more):

☐ I am American Indian, Alaska Native, or California Indian

☐ I am eligible for services through Indian Health Services

☐ I am a former foster child under 26 years of age and I was in foster care when I turned 18

☐ I am an inmate of a public institution

☐ I have a medical condition or health needs that impact ability to work or do other community engagement activities (check one below)

- ☐ I am blind or disabled, as determined under section 1614 of the Social Security Act
- ☐ I have a substance use disorder (SUD) where I have not been in stable recovery for 5 or more years
- ☐ I have a disabling mental disorder — for example, schizophrenia, major depressive disorder, or panic disorder
- ☐ I have a physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living— for example, cerebral palsy, muscular dystrophy, spinal cord or brain injury, or Down syndrome
- ☐ I have a serious or complex medical condition — cancer, COPD, HIV/AIDS, heart disease, ALS, Parkinson's disease, or multiple sclerosis

☐ I am a parent, guardian, caretaker relative, or family caregiver of a dependent child under age 14 or a disabled individual

☐ I am a participant in an alcohol or drug addiction treatment program

☐ I am pregnant or postpartum (12 months or less)

☐ I am a veteran with a disability rated as total (rating of 100%)

☐ I am eligible for Medicare

☐ I was recently incarcerated in the last three months

☐ I require necessary travel for medical services not available in the community for a serious medical condition

☐ I am an individual receiving inpatient or institutional services

CE Qualifying Activities Attestation Statement (if applicable) – If no exclusions apply, check the qualifying activities completed in the month prior to application.

☐ Work — working a job where you receive income or are compensated in-kind

☐ Community service or volunteering — community service with a not-for-profit organization with a valid Tax ID

☐ Workforce training or job readiness programs — participating in a work program approved by DPHHS

☐ Internships or registered apprenticeships — unpaid work, participating in a program approved by DPHHS

☐ Going to school — enrolled in an institution of higher education, career and technical education program, or high school/GED

(Applicant OR Parent/Guardian/Other) – I understand the questions on this application and the penalty or withholding or giving false information. I certify, under penalty of perjury, all my answers are correct and complete to the best of my knowledge.

Applicant Name (Please Print): _____

Applicant Signature: _____

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: _____

Facility: _____

QE Name (print): _____

QE Signature: _____

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 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 rule.