PROVIDER INSTRUCTIONS
PRESUMPTIVE ELIGIBILITY APPLICATION

DETACH THIS INSTRUCTION SHEET. THESE INSTRUCTIONS WILL GUIDE YOU THROUGH THE PRESUMPTIVE ELIGIBILITY PROCESS.

FORMS and materials needed to determine Presumptive Eligibility:

1. MA 332 - Presumptive Eligibility Application
2. MA 332A - Presumptive Eligibility Family Size/Income Chart
3. PA 600P - Provider Application Packet containing Provider Instructions, Provider Addendum, and Application for Benefits (PA 600).

WHEN APPLICATION SHOULD BE MADE

Applications for Presumptive Eligibility must be filed at the office of a designated qualified provider. The application is completed and signed when a patient with a verified pregnancy requests assistance in paying the medical expenses associated with her pregnancy. In addition, providers should suggest that a patient with a verified pregnancy complete an application if the patient does not have medical insurance coverage or if the patient indicates she does not have sufficient financial resources to pay for continued prenatal care. **PLEASE NOTE: Only one period of Presumptive Eligibility is permitted per individual per pregnancy per qualified provider.**

ELIGIBILITY DETERMINATION

Presumptive Eligibility is determined by a qualified provider. If the patient qualifies for Presumptive Eligibility, the provider should assist the patient in completing the designated sections of the PA 600. The county assistance office will contact the applicant to schedule an appointment to review the PA 600 and to determine eligibility for ongoing medical assistance benefits for the applicant. The MA 332 and the PA 600 must be properly completed and submitted by the qualified provider to the appropriate county assistance office (CAO). The MA 332 and PA 600 must be received by the CAO within 5 workdays. The CAO can then authorize Presumptive Eligibility for a temporary period not to exceed 45 days, pending a determination of eligibility for regular medical assistance.

INSTRUCTIONS FOR COMPLETING THE MA 332

Please follow the instructions for completing the Presumptive Eligibility Application. The county assistance office (CAO) will not be able to process the Presumptive Eligibility Application if the application is not completed accurately and received by the CAO within 5 workdays from the signature date.

PART A - TO BE COMPLETED BY THE APPLICANT AND REVIEWED BY THE QUALIFIED PROVIDER. The provider may assist the applicant in completing this section if necessary.

YOUR NAME:	Applicant's full name (last, first, middle initial)
COUNTY OF RESIDENCE:	County where the applicant resides
PHONE NUMBER:	Number where the applicant can be contacted (including area code)
YOUR ADDRESS:	Applicant's home address

QUESTION 1: If the applicant answers **yes** to this question, check the appropriate block in Part B, # 5 and refer to instructions **"FOR THE INELIGIBLE APPLICANT."** Ask to see the applicant's M.A.I.D. card to bill for covered services. If the applicant has a green M.A.I.D. card, advise her that additional medical assistance benefits may be available through the county assistance office.

QUESTION 2: If the applicant answers **no** to this question, check the appropriate block in Part B, # 5 and refer to instructions **"FOR THE INELIGIBLE APPLICANT."** Refer the applicant to the CAO in her county of residence for assistance.

QUESTION 3: If the applicant answers **no** to this question, check the appropriate block in Part B, # 5 and refer to instructions **"FOR THE INELIGIBLE APPLICANT."** Refer the applicant to the CAO in her county of residence for a determination of medical assistance eligibility.

QUESTION 4: Number of family members residing with the applicant (including the applicant).

QUESTION 5: List the total combined monthly income of the individuals included in the answer to Question 4.

SIGNATURE: Applicant or applicant's representative must sign the application form.

DATE: Date application was completed.

PART B - TO BE COMPLETED BY THE QUALIFIED PROVIDER.

QUESTION 1: If **no,** reject application, check the appropriate block in # 5 and follow instructions in the section **"FOR THE INELIGIBLE APPLICANT."**

QUESTION 2: Indicate the expected delivery date given by the attending physician.

QUESTION 3: **Add** the unborn to the number listed in Part A, Question 4, and enter total here. **EXAMPLE: A woman pregnant with twins would be counted ad three (3) family members.**

INCOME ELIGIBILITY

Compare the household's monthly income as listed by the applicant in Part A, Question 5, and the family size including the unborn in Part B, Question 3, to the Presumptive Eligibility Family Size/Income Chart, MA 332A.

The applicant is presumptively eligible if the household's total monthly income is **equal to or less than** the Monthly Income figure for the appropriate family size **- CHECK BLOCK 4.**

The applicant is not presumptively eligible if the household's total monthly income is **greater than** the Monthly Income figure for the appropriate family size **- CHECK THE APPROPRIATE BLOCK IN # 5.**

1. Type or print name and address, telephone no., and M.A.I.D. Number of the provider.

2. Sign and date the application in Part B. **The date should be the same as the date the applicant signed Part A.** The application may be signed by the attending physician, clinic director, or designee.

FOR THE ELIGIBLE APPLICANT

1. Have the applicant complete the following items on the PA 600:

   Page 1 Last Name, First Name, Middle Initial, Social Security Number, Complete Address, and Home Phone Number. Have the applicant sign and date the application in this section.

   Page 2 Last Name, First Name, Middle Initial, Birthdate, Age, and Social Security No.

   Note: Please review the PA 600 to ensure the applicant has completed all required fields. If the PA 600 is not completed as defined above, the CAO will return the application packet to you and processing of Presumptive Eligibility will be delayed.

2. **Distribute the MA 332 as follows:** Give applicant the Applicant Copy, retain Provider Copy for your file, staple the DPW and Confirmation Copies **to the PA 600** and send to the county assistance office in the applicant's **county of residence.** The county assistance office must receive the Presumptive Eligibility packet within 5 workdays. Obtain the address of the appropriate county assistance office from the listing in the Appendix of your Provider Handbook.

FOR THE INELIGIBLE APPLICANT

1. **Distribute the MA 332 as follows:** Give applicant the Applicant Copy and retain Provider Copy for your file. Mail the DPW Copy to the Department. This copy is designed to form a pre-addressed envelope. Fold as shown on the back of the DPW Copy, seal with tape, and mail. It is not necessary to retain the Confirmation Copy.

2. Inform the applicant she has the right to file a formal application for medical assistance at her local county assistance office.

Part C - TO BE COMPLETED BY COUNTY ASSISTANCE OFFICE

PRESUMPTIVE ELIGIBILITY APPLICATION

PART A - TO BE COMPLETED BY APPLICANT OR APPLICANT'S REPRESENTATIVE

YOUR NAME - Last, First, Middle Initial	COUNTY OF RESIDENCE	TELEPHONE NUMBER ( )
YOUR ADDRESS - Street, Apt. #, City, State		ZIP CODE

1. DO YOU HAVE A CURRENT MEDICAL ASSISTANCE CARD? ☐ YES ☐ NO
2. ARE YOU A RESIDENT OF PENNSYLVANIA? ☐ YES ☐ NO
3. ARE YOU A CITIZEN OF THE UNITED STATES OR AN ALIEN LAWFULLY ADMITTED FOR PERMANENT RESIDENCE? ☐ YES ☐ NO
4. HOW MANY FAMILY MEMBERS LIVE WITH YOU? - INCLUDE YOURSELF ▷
5. WHAT IS YOUR HOUSEHOLD'S MONTHLY INCOME? ▷ $

   Include wages, salaries, tips, self-employment, dividends, interest, child support, alimony, Social Security, veteran's benefits, Unemployment Compensation, Workers Compensation or sick benefits, retirement benefits or pensions, rental income, cash contributions, etc.

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT.

SIGNATURE - APPLICANT OR REPRESENTATIVE _____ DATE _____

PART B - TO BE COMPLETED BY QUALIFIED PROVIDER

APPLICANT HAS A MEDICALLY VERIFIED PREGNANCY 1. ☐ YES ☐ NO	EXPECTED DATE OF DELIVERY 2.	3. FAMILY SIZE INCLUDING THE UNBORN ▷

4. ☐ APPLICANT IS PRESUMPTIVELY ELIGIBLE, AND HAS BEEN ADVISED THAT SHE WILL BE CONTACTED BY THE COUNTY ASSISTANCE OFFICE - A COMPLETED PA 600 IS ATTACHED. REFERRED TO WIC/DEPT. OF HEALTH
5. APPLICANT IS NOT PRESUMPTIVELY ELIGIBLE FOR THE FOLLOWING REASON:
   ☐ M.A. RECIPIENT ☐ NOT A PA RESIDENT ☐ NOT A U.S. CITIZEN OR LEGAL ALIEN ☐ EXCESS INCOME ☐ NOT PREGNANT

   APPLICANT HAS BEEN ADVISED THAT SHE MAY APPLY FOR MEDICAL ASSISTANCE AT THE COUNTY ASSISTANCE OFFICE. REFERRED TO WIC/DEPT. OF HEALTH.

PROVIDER NAME	PROVIDER M.A.I.D. NUMBER	TELEPHONE NUMBER ( )
ADDRESS - Street, City, State		ZIP CODE

AUTHORIZED SIGNATURE _____ DATE _____

PART C - TO BE COMPLETED BY THE COUNTY ASSISTANCE OFFICE

APPLICANT'S NAME - Last, First, Middle Initial
1.

PRESUMPTIVE ELIGIBILITY AUTHORIZATION 2. BEGINS MO DAY YEAR ENDS MO DAY YEAR	FOR PRESUMPTIVE ELIGIBILITY INVOICING INFORMATION ONLY CO. RECORD NUMBER CATEGORY CTR. DIG. LINE NO.

3. ☐ APPLICANT IS ELIGIBLE FOR ONGOING MEDICAL ASSISTANCE-BEGINNING MO DAY YEAR — YOU MUST SEE APPLICANT'S VALID M.A.I.D. CARD
4. ☐ APPLICANT IS NOT ELIGIBLE FOR ONGOING MEDICAL ASSISTANCE

   REASON FOR REJECTION:
   ☐ EXCESSIVE INCOME
   ☐ FAILURE TO KEEP APPOINTMENT
   ☐ OTHER _____

CAO WORKER'S SIGNATURE _____ DATE _____

DPW COPY

MA 332 5/06