ATTACHMENT I

SCREENING CHECKLIST

MEDICAID PRESUMPTIVE ELIGIBILITY APPLICATION FOR NURSING FACILITY, HOSPICE, OR HOME CARE SERVICES

DATE:	NAME AND ADDRESS OF HOSPITAL:
APPLICANT NAME (AND C/O NAME IF PRESENT) AND ADDRESS:	NAME OF HOSPITAL PERSONNEL COMPLETING THIS FORM (PLEASE PRINT): Telephone Number:

To be eligible to participate in the presumptive eligibility program, an individual must reasonably appear to be eligible for Medicaid. If ANY of the following boxes is checked YES, based on documentation or statements of the applicant (or authorized representative), the individual is NOT eligible to participate:

	YES	NO
The individual has insurance which fully covers the care he or she will be receiving upon discharge from the hospital for at least 60 days from the date of the presumptive eligibility application.	☐	☐
The individual is not a citizen, not a naturalized citizen, or not an alien who has been both lawfully admitted for permanent residence and was admitted prior to August 22, 1996, or has resided in the United States for at least five years.	☐	☐
The individual or the individual's non-applying spouse fails or refuses to make his or her income and/or resources available to the other spouse.	☐	☐
For spousal impoverishment cases, the couple's combined countable assets (excluding the home) exceed $78,270.	☐	☐
The individual (and/or spouse) is the grantor and/or beneficiary of a trust (except a burial trust).	☐	☐
The individual (and/or spouse) owns real property other than the home.	☐	☐
The individual (and/or spouse) transferred assets within the previous 36 months.	☐	☐
The individual is Home Relief-related (i.e., over age 21 and under age 65, and not certified blind/disabled).	☐	☐

Date: ____________________

ATTACHMENT II

PRESUMPTIVE MEDICAID ELIGIBILITY PROGRAM
MEDICAL DOCUMENTATION TRANSMITTAL FORM

TO:

FROM:

PATIENT NAME & ADDRESS:

Social Security Number:

Estimated Date of Discharge from the Hospital:

Type of care needed:

☐ Nursing Facility ☐ Inpatient Hospice ☐ Community Hospice ☐ LTHHCP ☐ CHHA

MONTHLY CHHA SERVICES NEEDED:

Type of Service:	Hrs/Visits Needed:	Frequency
______	______	______
______	______	______
______	______	______
______	______	______

Proposed Provider Name and Address:	Medicaid ID#:
Contact Person:	

Attachments:

☐ Physician Statement

☐ Programmatic Service documentation requirements (e.g., PRI, DMS-1)

☐ Hospice Election Form

☐ Other: ____________________

AVERAGE REGIONAL MEDICAID NURSING FACILITY PER DIEM RATES AND UPSTATE AND NEW YORK CITY/METRO ALTERNATE LEVEL OF CARE RATES

Note: 65% of the per diem is provided in bold next to the per diem rate.

$123.53/**$80.29**
NORTHEASTERN

Albany
Clinton
Columbia
Delaware
Essex
Franklin
Fulton
Greene
Hamilton
Montgomery
Otsego
Rensselaer
Saratoga
Schenectady
Schoharie
Warren
Washington

$149.52/**$97.19**
NORTHERN METROPOLITAN

Dutchess
Orange
Putnam
Rockland
Sullivan
Ulster
Westchester

$114.27/**$74.28**
WESTERN

Allegany
Cattaraugus
Chautauqua
Erie
Genesee
Niagara
Orleans
Wyoming

$167.61/**$108.95**
LONG ISLAND

Nassau
Suffolk

$190.00/**$123.50**
NEW YORK CITY

Bronx
Kings (Brooklyn)
New York (Manhattan)
Queens
Richmond (Staten Island)

$127.77/**$83.05**
ROCHESTER

Chemung
Livingston
Monroe
Ontario
Schuyler
Seneca
Steuben
Yates
Wayne

$118.73/**$77.17**
CENTRAL

Broome
Cayuga
Chenango
Cortland
Herkimer
Jefferson
Lewis
Madison
Oneida
Onondaga
Oswego
St. Lawrence
Tioga
Tompkins

ALTERNATE LEVEL OF CARE (ALC) RATES

NEW YORK CITY/METRO REGION: $192.54

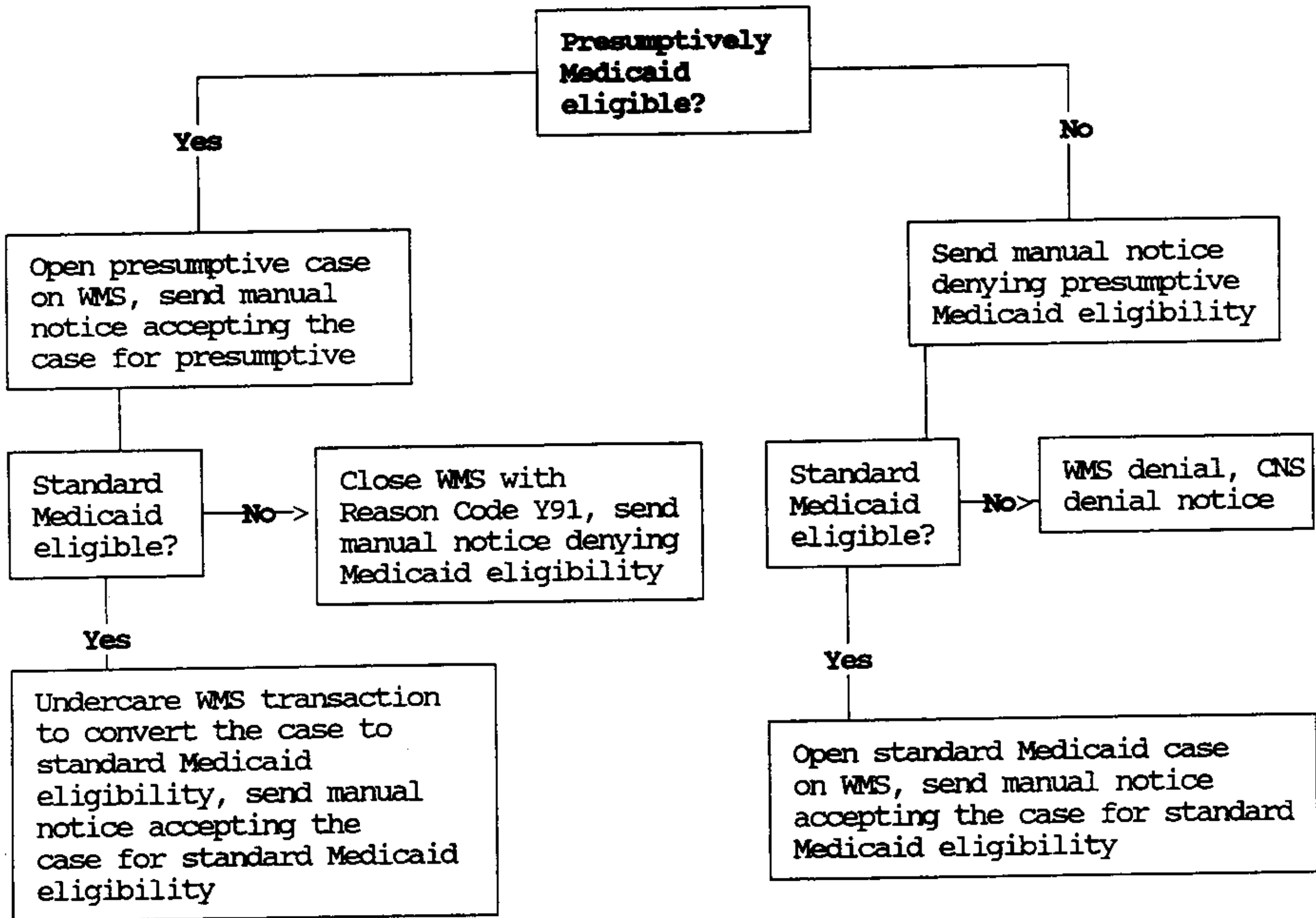
Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland

UPSTATE: $126.00

Rest of state

PRESUMPTIVE MEDICAID ELIGIBILITY

UPSTATE SYSTEMS AND NOTICES FLOWCHART



NOTICE OF DECISION ON YOUR PRESUMPTIVE MEDICAID ELIGIBILITY APPLICATION FOR HOME HEALTH OR COMMUNITY HOSPICE CARE SERVICES

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP ______

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This Department has made a decision concerning your Medicaid application for presumptive eligibility dated ________. We are sending this notice to tell you that this Department will:

☐ ACCEPT your presumptive Medicaid eligibility application from ______________ to ____________________ pending verification of information in your application.

Please note that Medicaid does not cover hospital-based clinic services, hospital emergency room services, acute hospital inpatient services (except when provided as part of hospice care), and bedhold during the presumptive eligibility period.

Your total unverified monthly income is $________. The difference between your net income and the Medicaid level is $________. This is called your monthly surplus income. Each month, Medicaid will pay medical expenses above this figure that are incurred during the month. This figure will be adjusted as necessary to the extent that your verified income is higher or lower than you have indicated.

In addition to any income contribution, $________ of excess resources must be contributed toward the cost of care from ________ to ____________.

If, upon full determination of eligibility, it is established that you are not eligible for Medicaid, any medical bills paid on your behalf will be subject to recovery action by the agency. In addition, the provider may seek reimbursement for that portion of the bill not paid by Medicaid.

☐ DENY your application for presumptive Medicaid eligibility for home health or hospice care because:

____

____

____

____

We will contact you to schedule an interview with you to determine your eligibility for regular Medicaid coverage.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOMES, RESOURCES, LIVING ARRANGMENTS OR ADDRESS

NOTICE OF DECISION ON YOUR PRESUMPTIVE MEDICAID ELIGIBILITY APPLICATION FOR COVERAGE OF NURSING FACILITY SERVICES OR INPATIENT HOSPICE CARE

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP ____________

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This Department has made a decision concerning your Medicaid presumptive eligibility application dated ____________. We are sending this notice to tell you that this Department will:

☐ ACCEPT your presumptive eligibility application for Medicaid coverage effective from ____________ to __________ pending verification of information in your application.

Please note that Medicaid does not cover hospital-based clinic services, hospital emergency room services, acute hospital inpatient services (except when provided as part of hospice care), and bedhold during the presumptive eligibility period. We have calculated the total monthly contribution toward the cost of this individual's care for the periods indicated:

From ________ **To** ________		**From** ________ **To** ________	
Gross Monthly Income	$________	Gross Monthly Income	$________
Deductions	- ________	Deductions	- ________
Net Monthly Income	$________	Net Monthly Income	$________
Income Allowance Personal Needs Allowance/MA Level	-$________	Income Allowance Personal Needs Allowance/MA Level	-$________
Contribution to Community Spouse	- ________	Contribution to Community Spouse	- ________
Family Member Allowance(s), or Dependent Household Member(s)	- ________	Family Member Allowance(s), or Dependent Household Member(s)	- ________
Costs of Medical/ Remedial Care	- ________	Costs of Medical/ Remedial Care	- ________
Remaining Available Monthly Income	= ________	Remaining Available Monthly Income	= ________
Contribution from Spouse	+ ________	Contribution from Spouse	+ ________
Restricted Income	+ ________	Restricted Income	+ ________
Total Income Contribution per mo.	$ ________	Total Income Contribution per mo.	$ ________
		Payable to: ________________	

In addition to any income contribution, $________ of excess resources must be contributed toward the cost of care from __________ to ____________. Your total monthly contribution toward the cost of care will be adjusted to the extent your verified income/resources are higher or lower than you have indicated. If, upon full determination of eligibility, it is established that you are not eligible for Medicaid, any medical bills paid on your behalf will be subject to recovery action by the agency. In addition, the provider may seek reimbursement for that portion of the bill not paid by Medicaid.

☐ DENY your Medicaid application for presumptive eligibility, because:

____

____

____

We will contact you to schedule an interview with you to determine your eligibility for regular Medicaid coverage.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOMES, RESOURCES, LIVING ARRANGMENTS OR ADDRESS