



STATE OF MARYLAND
DHMH

To find out if you qualify for regular Medicaid or other health coverage, you must complete this application for Temporary Eligibility. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through Temporary Eligibility for Medicaid.

APPLICATION FOR HOSPITAL PRESUMPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL ASSISTANCE

PART I – INFORMATION FOR DETERMINATION (ITEMS LABELED WITH ‘*’ ARE REQUIRED)

*First Name :	*Middle Name:	*Last Name:	Suffix:
*Family Size:	*Household Gross Monthly Income:		*Maryland Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Date of Birth: ____/____/____	*U.S. Citizen, U.S. National or Qualified Non-Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
If readily available, also tell us the following:			
*Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	*If yes, when is your due date? *How many babies are you expecting?	Social Security Number: _____ - ____ - _____	
Other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	*In Foster Care at age 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Already have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Already have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No

PART II – IMPORTANT CONTACT INFORMATION

*Home Address:			
*City:	*State:	*Zip Code:	*County:
Mailing Address (if different):			
City:	State:	Zip Code:	County:
*Telephone:			
Home	Work	Cell	
E-mail address:			

PART III – PRESUMPTIVE DETERMINATION: Hospitals representative must make the determination based on the REQUIRED information in Part I only and give the applicant an approval or denial notice.

Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <u>check</u> the eligibility group:		
	<input type="checkbox"/> Child (Medicaid)	<input type="checkbox"/> Pregnant Woman	<input type="checkbox"/> Former Foster Youth <26
	<input type="checkbox"/> Child (MCHP)	<input type="checkbox"/> Parent/caretaker relative	<input type="checkbox"/> Adult

PART IV – SIGNATURES

Applicant: By signing, you are attesting that the information you provided for this form is true as far as you know and that you have received a copy of the Approval Notice that lists your Rights and Responsibilities, or a Denial Notice. We will keep your information secure and private.

_____ Signature of Applicant (or legal guardian)	_____ Date
_____ Signature of Authorized Representative (if applicant unable to sign)	_____ Relationship to Applicant
	_____ Date

Hospital Representative: By signing, you are attesting that you have accurately recorded the information provided by the applicant or someone representing the applicant, made a determination based on that information, and provided the applicant with an Approval Notice that lists their Rights and Responsibilities or a Denial Notice.

_____ Signature of Hospital Representative	_____ Date
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