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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-16-0005-MM

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages
4) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

December 12, 2016

Joseph K. Miner, M.D., MSPH, Executive Director
Utah Department of Health
P.O. Box 141000
Salt Lake City, UT 84114- 1000

RE: Utah #16-0005-MM

Dear Dr. Miner:

Enclosed is an approved copy of Utah's state plan amendment (SPA) 16-0005-MM, which was submitted to CMS on December 23, 2015, and contains an amendment to the MAGI-Based Eligibility S21 template for Hospital Presumptive Eligibility. This amendment elects to use the single streamline application as well as make revisions to the training materials effective January 1, 2016.

Please be informed that this State Plan Amendment was approved December 9, 2016 with an effective date of January 1, 2016. We are enclosing the following:

- Summary Form (similar to the CMS-179)
- S21 template
- Attachment 1 – Alternative single streamlined paper application
- Attachments 2 & 3 – Hospital Presumptive Eligibility Training Materials and PowerPoint Slides

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Mandy Strom at mandy.strom@cms.hhs.gov or (303) 844-7068.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

cc: Nathan Checketts, Medicaid Director, UT
Jeff Nelson, UT
Craig Devashrayee, UT

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Utah**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

UT-16-0005

Proposed Effective Date

01/01/2016 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Pub. L. No. 111-148

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 0.00
Second Year	2017	$ 0.00

Subject of Amendment

Presumptive Eligibility by Hospitals

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:
- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Craig Devashrayee**
Last Revision Date:	**Dec 6, 2016**
Submit Date:	**Dec 23, 2015**

Medicaid Eligibility

State Name: Utah

OMB Control Number: 0938-1148

Transmittal Number: UT - 16 - 0005

Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

■ Pregnant Women

■ Infants and Children under Age 19

■ Parents and Other Caretaker Relatives

■ Adult Group, if covered by the state

■ Individuals above 133% FPL under Age 65, if covered by the state

■ Individuals Eligible for Family Planning Services, if covered by the state

■ Former Foster Care Children

■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

Medicaid Eligibility

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

(•) Yes ( ) No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

The State has set a standard for hospitals to provide 100% of all PE applications completed by the hospital site to the Department of Workforce Services (DWS). DWS enters the PE decision into the client eligibility system and issues medical assistance cards to eligible individuals.

The hospital PE application can be used to apply for ongoing assistance. Applicants only have to answer the questions required to make the PE decision and sign that paper application. The hospital staff are expected to let individuals know that they can apply for ongoing assistance using the PE application, and must offer assistance to applicants in completing the application. Individuals are encouraged, but not required to complete the full application if they want to use the PE application to apply for ongoing assistance. Applicants for PE may choose not to submit a full application at the time they are doing the PE application. The applicant may also choose to apply later using a different application process. The hospital PE application includes a question about using the PE application to apply for ongoing medical assistance.

DWS will accept the PE application as a full application for ongoing medical assistance when the applicant indicates he wants to apply for ongoing assistance. If a client does not indicate he wants to apply for ongoing assistance, DWS only enters the information about the PE decision, and issues a medical card for presumptive eligibility only.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards:

The State has set a standard that the hospital will maintain an 85% accuracy rate for its presumptive eligibility decisions based on the information provided by the applicant. The State will conduct periodic reviews of PE applications received from the various sites, and randomly select a sample of cases to review to decide if the hospital made the correct PE decision based on the information provided by the applicant. The State will conduct additional training when a site has a lower accuracy rate, and take corrective actions if needed, which may include disqualifying a site if improvement does not occur. The state will increase this standard as the hospitals have had time to learn the process, and based on the findings from reviews.

For presumptively eligible individuals who submit applications for ongoing medical assistance, the State has set a standard that 65% of those will be determined eligible for ongoing Medicaid. We have set the standard based on eligibility statistics from our Presumptive Eligibility for Pregnant Women program. We will initially use a slightly lower standard for the hospitals than the average rate of eligibility the state has seen for Pregnant Women cases because this is a new process for hospitals and it includes different populations. The state will utilize data about the number of PE cases approved and denied ongoing medical assistance to decide if a site is meeting this standard. The state may adjust the standard in the future based on its findings. from reviews.

Based on the findings from reviews, the state will schedule additional training or take other corrective actions to improve the success rate of hospitals that are not meeting these standards. If a hospital continues to be unable to meet the performance standards after corrective actions have taken place, the state can disallow the hospital from continuing to make presumptive eligibility determinations.

Medicaid Eligibility

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

- ◉ No more than one period within a calendar year.
- ○ No more than one period within two calendar years.
- ○ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- ○ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

- ◉ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
- ○ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

■ The presumptive eligibility determination is based on the following factors:

- ■ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
- ■ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.
- ☒ State residency
- ☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Please tear this page off and keep it for your information.

UTAH DEPARTMENT OF HEALTH MEDICAID

APPLICATION INFORMATION

CHIP | PCN | UPP | MEDICAID | HPE | BYB | PRIVATE HEALTH INSURANCE | APTC

WHAT AM I APPLYING FOR?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program)**
  Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip
- **PCN (Primary Care Network)**
  Provides primary preventive health coverage for uninsured adults who qualify based on family size and income. For more information, visit: www.health.utah.gov/pcn
- **UPP (Utah's Premium Partnership for Health Insurance)**
  Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA. For more information, visit: www.health.utah.gov/upp
- **Medicaid**
  Provides medical benefits for low-income families, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: medicaid.utah.gov
- **HPE (Hospital Presumptive Eligibility)**
  Provides temporary Medicaid coverage for parents/caretaker relatives, children, pregnant women, and former foster care individuals who qualify based on preliminary information.
- **BYB (Baby Your Baby)**
  Provides temporary Medicaid coverage for pregnant women who qualify based on preliminary information. For more information, visit: www.babyyourbaby.org
- **Private Health Insurance**
  Provides comprehensive coverage to help you stay well. This is offered through the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov
- **APTC (Advanced Premium Tax Credit)**
  This is a tax credit that can immediately help pay your premiums for health coverage in the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov

WHAT DO I NEED TO DO NEXT?

On your application, tell us about all of your family members who live with you. You can apply for and get benefits for eligible family members, even if your family includes other members who are not eligible because of their immigration status. For example, U.S. citizens or legal immigrant children may qualify for benefits even though their parents may not qualify. If you file taxes, we need you to tell us about everyone on your tax return. *(Note: You don't need to file taxes to get health coverage.)* The program you qualify for depends on the number of people in your family and their income. This information helps us make sure everyone gets the best health coverage.

See back of this cover sheet for more instructions.

WHAT DO I NEED TO DO NEXT? (CONT.)

Follow the instructions below based on the program(s) that you are applying for:

CHIP, PCN, UPP, Medicaid, Private Health Insurance, and/or APTC

- You may apply online at jobs.utah.gov/mycase OR fill out this application and return it to:

  Department of Workforce Services
  PO Box 143245
  SLC, UT 84114-3245
  Fax: 1-801-526-9505
  Toll-free Fax: 1-888-522-9505

- Skip page 8 of the application if you are NOT applying for Hospital Presumptive Eligibility or Baby Your Baby.

- You may be asked to have your employer fill out the "Employer's Health Insurance Form" (Attachment C). Please keep this form in case you are asked to do so.

- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.

HPE or BYB

- We can best determine your eligibility if all questions are answered. However, for HPE and BYB, at a minimum you must fill out the questions on the four pages listed below.

  Page 1 Section A: Name, Address, Phone#
  Section B: Question 1 Only
  Page 2 Section C: Questions 1, 6, and 9
  (For BYB, question 6 is not required.)
  Page 8 Section K: All Questions
  (For BYB, question 6 is not required.)
  Page 10 Section L: Signature

- The hospital or clinic will determine HPE or BYB eligibility and will forward your application to the Department of Workforce Services (DWS) to determine continued medical benefits. DWS will notify you of your eligibility decision. If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.

- Applying for continued medical benefits is not a requirement for HPE or BYB. If you choose not to apply, refer to number 8 on page 8.

WHERE CAN I GET MORE INFORMATION OR HELP?

- Translation services are available if you need help during the application process.
- Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711 or Spanish Relay Utah by dialing 1-888-346-3162.
- For answers to your questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase
- If you have questions about how to complete the application and/or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid or PCN, call the Medicaid Hotline at 1-800-662-9651.
- For general questions about CHIP, PCN or UPP, call the Health Information Hotline at 1-888-222-2542.

APPLICATION

A APPLICANT INFORMATION

Name: _____
first (start with yourself) middle initial maiden last

Home Address: _____
(leave blank if you don't have one) street apt.# city state zip

Mailing Address: _____
(if different from home address) street apt.# city state zip

Home Phone: (_____)_____ Cell/Other Phone: (_____)_____

E-mail (optional): _____

☐Yes ☐No Do you speak English? If no, what is your primary language? _____

Would you like to receive notices in English or Spanish? ☐English ☐Spanish

B HOUSEHOLD INFORMATION

1. List everyone who is living in your household. Check the box for those applying for health coverage.

Name (first, m.i., last) ☑ Check box if applying for coverage.	Relation to You	[1]Social Security#	Birth Date (mm/dd/yy)	Sex (f/m)	[2]Race	[3]Ethnicity	[4]Marital Status	Full Time Student (y/n)	Utah Resident [1]U.S. Citizen/ National Eligible Non-Citizen
☐	Self								☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen

[1]Social Security Number & Citizenship: Social Security Number (SSN) and citizenship information are only needed for people applying for benefits. SSN is not required for people applying for presumptive eligibility. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

[2]Race Codes (Optional): **WH:** White, **BL:** Black/African American, **AI:** American Indian/Alaska Native, **ASI:** Asian Indian, **CH:** Chinese, **FI:** Filipino, **JA:** Japanese, **KO:** Korean, **VI:** Vietnamese, **OA:** Other Asian, **NH:** Native Hawaiian, **SA:** Samoan, **GC:** Guamanian/Chamorro, **OPI:** Other Pacific Islander, **OT:** Other

[3]Ethnicity Codes (Optional): **N:** Not Hispanic/Latino, **M:** Mexican, **MA:** Mexican American, **CH:** Chicano/a, **PR:** Puerto Rican, **CU:** Cuban, **AH:** Another Hispanic, Latino, or Spanish Origin, **OT:** Other

[4]Marital Status: Single, Married, Divorced, Widowed

B HOUSEHOLD INFORMATION (CONT.)

2. If you are an American Indian or Alaska Native, please complete Attachment A as this can help you receive better benefits.
3. If anyone in your household has an eligible immigration status and is applying for benefits, complete the chart below.

Name	Immigration Document Type	Alien or I-94#	Document ID# *(if different from Alien#)*	Lived in the U.S. Since 1996? (y/n)	Is a veteran or an an active-duty member of the U.S. military, or has spouse or parent who is (y/n)

C GENERAL INFORMATION

Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do ALL individuals who are applying for medical benefits have a Utah Medicaid card *(This card is used for both Medicaid and PCN)*?
If no, who needs a card? _____

☐Yes ☐No 2. Do you want help paying any medical bills from the last 3 months?
If yes, for who:_____ For which month(s):_____

☐Yes ☐No 3. Do you want help paying for COBRA or your employer's health insurance plan?

☐Yes ☐No 4. Does anyone who is applying for coverage have a major medical need? This includes cancer, kidney disease, heart disease, etc. *(Answering this question may get you extra help.)*
If yes, who:_____
What is the medical need?_____

☐Yes ☐No 5. Are you the primary person taking care of a child living in your home under age 19?

☐Yes ☐No 6. Was anyone who is applying for coverage in foster care on or after his/her 18th birthday?
If yes, who:_____
Did he/she receive Medicaid at that time? ☐Yes ☐No

☐Yes ☐No 7. Does anyone who is applying for coverage have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:_____

☐Yes ☐No 8. Is anyone who is applying for coverage living in an institution (such as a hospital, nursing home, jail, or prison)?
If yes, who: _____ When:_____ How long: _____

☐Yes ☐No 9. Is anyone who is applying for coverage currently pregnant or has been pregnant in the last 3 months?
If yes, who:_____ Due date:_____
How many babies are expected during the pregnancy? _____
Has she smoked or used tobacco in the past 6 months? ☐Yes ☐No
(Information about tobacco use among pregnant women is needed only to determine potential eligibility for tobacco cessation programs. Response to this question is optional.)

☐Yes ☐No 10. Does any child who is applying for coverage have a parent living outside the home?
If yes, are you willing to cooperate with the Office of Recovery Services to establish medical support from an absent parent(s)? ☐Yes ☐No

D INCOME

☐Yes ☐No 1. Does anyone in your household have earned income?
If yes, list any earned income received by all people who live in your home.

Employed Person (name)	Employer Name, Address & Phone Number	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (tips, bonus, commission, etc.)
		/			
		/			

☐Yes ☐No 2. Does anyone in your household have self-employment income?
If yes, list any self-employment income received by all people who live in your home.

Self-Employed Person (name)	Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	Percent of Company Owned	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. Do you expect any changes in earnings or in the number of hours worked?
If yes, who: _____Explain change(s):_____

☐Yes ☐No 4. In the past year, did anyone in your household change jobs, stop working or start working fewer hours?
If yes, who:_____Explain change(s): _____

☐Yes ☐No 5. Does anyone in your household receive income from any of the following?

Check All That Apply Below:	Gross Amount Before Any Deductions	How Often	Approximate Start Date (month/year)	Name of Person Receiving the Income
☐Unemployment				
☐Pensions				
☐Social Security				
☐Retirement Accounts				
☐Alimony Received				
☐Net Farming/Fishing				
☐Net Rental/Royalty				
☐Other Income Type: _____				

E DEDUCTIONS

1. List the amount paid and how often you pay it. If you pay for certain things that cannot be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *(Note: You shouldn't include a cost already considered in your answer to net self-employment income.)*

Check All That Apply Below:	Amount Paid	How Often	Name of Person Paying the Expense
☐Alimony Paid			
☐Student Loan Interest Paid			
☐Other Deductions Type: _____			

☐Yes ☐No 2. Do you have pre-tax deductions taken out of your paycheck such as health insurance premiums and 401K contributions. If yes, complete the chart below.

Check All That Apply Below:	Amount	How Often	Name of Person with pre-tax deduction
☐Health Insurance Premium			
☐401K Contribution			
☐Other Pre-tax Deductions Type: _____			

F YEARLY INCOME

Complete only if your income changes from month to month. If you don't expect changes from month to month, skip to the next section.

Total income THIS year: _____

Total income NEXT year: _____
(if you think it will be different)

G TAX FILER INFORMATION

Please answer the following questions to help us select the program for your household. In addition to the questions below, please complete Attachment B of this application for all dependents that are not living with you, but are claimed on your tax return.

☐Yes ☐No 1. Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year?
If yes, complete the chart below. *(If you are claiming more than 5 dependents on your tax return, make a copy of this page to complete the information for the additional dependents.)*

Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?
Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?

H HEALTH INSURANCE INFORMATION

☐Yes ☐No 1. Does anyone in your household who is applying for coverage currently have Medicaid, CHIP, or Medicare?
If yes, check the type of coverage and write their names next to the coverage they have.
☐Medicaid: _____
☐CHIP: _____
☐Medicare: _____

☐Yes ☐No 2. Has anyone who is applying for coverage been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for your household's medical services?

☐Yes ☐No 4. Is anyone who is applying for coverage enrolled or eligible for COBRA coverage or continued health insurance through an employer? If yes, complete the chart below.

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including Veterans, Tricare, or Peace Corps.), have insurance available but not enrolled, or has had insurance in the past 6 months? If yes, complete the chart below.

INSURANCE 1

(Do not list Medicaid, Medicare, CHIP, or PCN)

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company: _____ Phone: _____

Address of insurance company: _____ Group#: _____

Policyholder name: _____ Policy#: _____

Policyholder birth date: _____ Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Federally Facilitated Marketplace (FFM)?

If insurance is through an employer, list employer's name and phone#: _____

Type of coverage: ☐Comprehensive ☐Limited

INSURANCE 2

(Do not list Medicaid, Medicare, CHIP, or PCN)

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company: _____ Phone: _____

Address of insurance company: _____ Group#: _____

Policyholder name: _____ Policy#: _____

Policyholder birth date: _____ Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Federally Facilitated Marketplace (FFM)?

If insurance is through an employer, list employer's name and phone#: _____

Type of coverage: ☐Comprehensive ☐Limited

OTHER TYPES OF MEDICAL PROGRAMS

If you or anyone applying for coverage are aged, blind, or disabled, living in a nursing home, applying for a Medicaid waiver program, or if you are over the income for the other Medicaid programs, you are required to answer the following questions. While these questions are optional to answer upfront, providing this information now will help us to process your application more quickly.

I OTHER BENEFITS, INCOME, AND EXPENSES

☐Yes ☐No 1. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment, or Worker's Compensation?
If yes, explain: _____

☐Yes ☐No 2. Has anyone in your household been determined disabled by Social Security?
If yes, who: _____

☐Yes ☐No 3. Does anyone in your household that has been determined disabled by Social Security pay child support or alimony?
If yes, list name, amount paid, and how often: _____

☐Yes ☐No 4. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: _____

☐Yes ☐No 5. Does anyone help you pay your mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name, amount paid, and how often: _____

J ASSETS

☐Yes ☐No 1. Do you or anyone in your household have any of the following financial assets? Check all that apply.

☐Annuity	☐401K/Retirement	☐Checking Account $_____
☐IRA	☐Money Market Fund	☐Savings Account $_____
☐Stock	☐Trust Fund	☐Other: _____
☐Bond	☐Time Certificate	

☐Yes ☐No 2. Do you or anyone in your household have any of the following assets? Check all that apply.

☐Land	☐Cemetery Plot	☐Rental/Investment Property
☐Home	☐Life Estate	☐Burial Plan/Fund
☐Tools	☐Timeshare	☐Other: _____
☐Camper/Trailer	☐Livestock	
☐Life Insurance	☐Mineral/Timber Right	

☐Yes ☐No 3. Do you own any vehicles?
If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snow mobiles, motorcycles, motor homes, boats/motors, ATVs, or other vehicles.

Make	Model	Year	Licensed (y/n)	License Plate#	State	Owner/Joint Owners	Amount Owed

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)
&
BABY YOUR BABY (BYB)

If there is anyone in your household who is applying for HPE or BYB, you are required to answer questions on this page in addition to the specified questions on page 1 and 2. Please refer to the Application Information coversheet to identify which specific questions on page 1 and 2 you must answer. Make sure you sign the application on page 10.

K HPE AND BYB QUESTIONS

☐Yes ☐No 1. Does anyone in your household have earned or unearned income?
Enter total monthly household earned income before taxes. $_____ (must complete.)
Enter total unearned income your household receives each month. $_____

☐Yes ☐No 2. Is anyone in your household who is applying for benefits, but is not a U.S. Citizen or National, an eligible non-citizen? If yes, complete the chart below.

Applicant's Name	Eligible Non-Citizen Status	Date Granted Status (month/year)

☐Yes ☐No 3. Is anyone in the household currently on Utah Medicaid, CHIP, PCN, UPP, BYB, HPE, or has been approved for Utah Medicaid with a spenddown?
If yes, who: _____

☐Yes ☐No 4. Has anyone in your household been denied Utah Medicaid, CHIP, PCN, or UPP in the last 30 days?
If yes, who: _____
If yes, what household circumstances changed since the denial? _____
_____

☐Yes ☐No 5. Has anyone in your household been approved for HPE in the last calendar year or if there is anyone pregnant, has she been approved for HPE or BYB for this pregnancy?
If yes, who: _____

☐Yes ☐No 6. Is there any child in the household who has a parent who is absent from the home, unable to work due to an injury or illness, deceased, receives Unemployment Benefits, or works less than 100 hours per month.
If yes, list the child(ren)'s name(s): _____

☐Yes ☐No 7. Does anyone in your household currently have health insurance? *(This information is optional.)*
If yes, complete the chart below.

Insurance Information	
Name(s) of individual(s) covered: _____	
Name of insurance company: _____	Phone: _____
Address of insurance company: _____	Group#: _____
Policyholder name: _____	Policy#: _____

8. Applying for continued medical benefits is not a requirement for HPE and BYB.
☐ By checking this box, I opt out of applying for continued medical benefits.

L I UNDERSTAND THAT:

The State of Utah (the State) referenced below includes the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- The State cannot discriminate against me due to my race, color, national origin, sex, age, sexual orientation, gender identity or disability as provided by federal law. I can file a complaint by visiting www.hhs.gov/ocr/office/file or contacting the DHHS Office for Civil Rights at 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 or 1-800-368-1019, 1-800-537-7697 (TDD).
- If I give any false information or fail to report changes, I may be prosecuted for fraud. Benefits may be reduced, denied or stopped because of the reported information. If I receive benefits I am not eligible to receive, I must repay the State.
- The State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older. The State will only collect after my spouse and I die.
- The State will not recover from my estate costs paid by the Medicare cost-sharing programs (QMB, SLMB, QI).
- I authorize the State to tell my healthcare providers if I am eligible for benefits. While I am eligible, the State may exchange information with my health insurance provider or employer.
- I must cooperate with the State in pursuing any third party responsible for medical expenses. I must cooperate with the State to establish medical support or paternity for my family. If I have good cause not to cooperate, I will not be required to cooperate.
- I must report any changes within 10 days. This includes changes in my income, address, phone number, household size, and access to health insurance coverage.
- I will receive a medical card for myself or others in my family if determined eligible. I will only allow the person named on the medical card to use it to receive services.
- I assure that all household members applying for medical assistance are U.S. citizens or aliens in lawful immigration status. Someone who only needs help for a medical emergency does not have to be a citizen or lawful alien. I do not have to report the citizenship information of someone who is not applying. The State verifies lawful alien status with the U.S. Citizenship and Immigration Service. The State will not report undocumented people in my home.
- The Utah Statewide Immunization Information System (USIIS) is an electronic registry. It keeps complete, up-to-date records of my child's immunization history. For more information, or to withdraw my child from USIIS, I can call 1-800-275-0659.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, I can visit www.mychie.org or contact my healthcare provider.
- If I receive payments under a long-term care partnership insurance plan, some assets may not count to decide my eligibility. In this case, the State will not recover medical costs from those assets after I die.
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I must pay any co-pays to providers when I receive services unless I am exempt from those co-pays.
- The medical benefits I may receive are described in the State's Provider Manuals. I am not eligible for services that are not listed in these manuals. I understand the State may change these manuals without my consent or knowledge.
- I must follow the medical assistance program rules. My spouse and/or children, if eligible, must also follow these rules.
- I authorize the State to verify any information provided. I understand this occurs when I apply for and after I receive benefits.
- If the State pays for my medical care, I assign to it my rights to payments for medical services from any third party. I will give the State any money I receive from an insurance policy or from someone who must pay my medical costs. I authorize payments be made directly to the State. I will hold harmless any party making payment to the State.
- I may ask for a fair hearing if I disagree with the decision made on this application.

I understand the State will use Social Security Numbers for those who are applying for benefits to make sure households are eligible for benefits. The State uses the State Income and Eligibility Verification System to do computer matches. The State uses the information it finds for benefit reviews and audits. The agencies that may receive, provide or use this information include: Workforce Services, Health, Human Services, Homeland Security, Social Security, and Internal Revenue Service. The State may also use information from consumer reporting agencies. The State may ask for information from banks or credit unions, and other organizations or people who may have eligibility information about my household. I must give the State proof that shows my household is eligible.

I, (print name) _____, have read the statements above or someone has read them to me. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know I may be subject to federal or state penalties if I give false or untrue information. Providing a Social Security Number and information pertaining to immigration or alien status is voluntary; however, any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.

_____ _____

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form, attached to this application.

M RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next
☐5 years (the maximum number of years allowed), or for a shorter number of years:
☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

N VOTER REGISTRATION INFORMATION

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of benefit that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

O RETURN COMPLETED FORM TO:

You have now completed the application. Please return this completed application form and any needed attachments to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

Please tear this page off and keep it for your information.

YOUR RIGHTS & RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- **Receive free language assistance services.**
  You have the right to an interpreter. Free language assistance services are available to you. Please call 801-526-0950 or see below:

  Spanish
  ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 801-526-0950.

  Chinese
  注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 801-526-0950.

  Vietnamese
  CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 801-526-0950.

  Korean
  주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-526-0950 번으로 전화해 주십시오.

  Navajo
  Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 801-526-0950.

  Nepali
  ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 801-526-0950 ।

  Tongan
  FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 801-526-0950.

  Serbo-Croatian
  OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 801-526-0950.

  Tagalog
  PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 801-526-0950.

  German
  ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 801-526-0950.

  Russian
  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 801-526-0950.

  Cambodian
  ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 801-526-0950។

  French
  ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 801-526-0950.

  Japanese
  注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。801-526-0950。

  Arabic
  ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 801-526-0950

Please tear this page off and keep it for your information.

YOUR RIGHTS & RESPONSIBILITIES (Cont.)

YOU HAVE THE RIGHT TO:

- **Apply or re-apply any time for medical benefits.**
  Some medical benefits are only available during open enrollment periods. If you need help to apply, ask for help from our staff.

- **Receive a notice when we approve or deny your application.**
  The notice will tell you the reason for the decision. For medical benefits, we have 30 days to process your application. We have 90 days if you claim to be disabled. You can ask for more time. If you need more time, let us know before the end of the 30 or 90 days.

- **Receive a notice when we reduce, stop or hold your medical benefits.**
  We will notify you 10 days in advance before we take any negative actions.

- **Look at information in your case.**
  Information about you and your case is confidential. We may give information to other agencies to decide if you are eligible for other benefits.

- **If you do not agree with decisions we make:**
  - Talk to your worker. Make sure you understand the decision.
  - Talk to your worker's supervisor.
  - Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  - Ask for a fair hearing. You have 90 days to ask for a hearing. If you ask within 10 days of the notice date, your benefits may continue during the hearing process.
  - You cannot have a hearing if you are denied for presumptive eligibility.
  - You may have a lawyer help with your fair hearing. You may qualify for free legal help from Utah Legal Services. In Ogden, call 1-801-394-9431 or in Salt Lake, call 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also ask for a referral for legal help from the Salt Lake Lawyer Referral at 1-801-531-9075.

YOU ARE RESPONSIBLE FOR:

- **Verifying information for us to decide if you are eligible for benefits.**
  - You must give us the Social Security Number (SSN) of each household member who wants medical benefits (Social Security Act (U.S.C. 1320 b - 7 (a) (1)). The State uses your SSN to make sure you are eligible. The State does computer matches through the State Income and Eligibility Verification System. The State uses computer match data for benefit reviews and audits. If you do not have a SSN, you must prove you have applied. You may be eligible for benefit while you wait for your number.
  - If you apply for Medicaid only to cover emergency services, you do not have to give us a SSN.

- **Cooperating and providing information about other sources of medical payments and on obtaining medical support.**
  If you feel you could be harmed by giving this information, you can ask for a "good cause" claim. Your worker can explain the process.

- **Utah Statewide Immunization Information System (USIIS)**
  The State enrolls children who receive Medicaid in USIIS. If you do not want your children enrolled in this system, call the USIIS HelpLine at 1-801-538-6872 or the Immunization Hotline at 1-800-275-0659.

- **Utah Clinical Health Information Exchange (cHIE)**
  If you receive medical benefits (Medicaid, CHIP, UPP, PCN), the State enrolls you in the cHIE. The cHIE provides a safe place for participating healthcare providers to share and view patient medical information. You may opt out of the cHIE at any time. For more information or to opt out of the cHIE, visit www.mychie.org or call your healthcare provider.

- **Cooperating on reviews of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy.**

- **Following medical benefit rules.**
  This applies to you and your medical household members.

Please tear this page off and keep it for your information.

CHANGES YOU MUST REPORT

Remember you are required to report changes in your situation WITHIN 10 DAYS of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount. To report changes, contact DWS online at www.jobs.utah.gov/mycase or call 1-866-435-7414.

IF YOU RECEIVE MEDICAL COVERAGE BENEFITS, YOU MUST REPORT:

- **Changes in Marital Status, Pregnancy Status, or Living Arrangement**
  Getting married, separated, or divorced; moving in with a roommate; changing an address or phone number; absent parent moving in; pregnancy; birth of a baby or end of a pregnancy; household member moving in or out; death of a household member; hospital stays for more than 30 days; anyone in your household going to jail or prison; receiving help with your household expenses, etc.

- **Changes in Source of Income**
  Getting a job, terminating a job, or working for temporary agencies; receiving educational income, SSI, SSA, or unemployment compensation, etc.; receiving a lump sum, such as SSA benefits or accident/injury awards.
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Amount of Earned or Unearned Gross Monthly Income**
  Working more OR less hours, overtime, getting a raise, etc.; change in the amount of SSI, SSA, Unemployment Compensation, etc.
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Any Asset(s)**
  Changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, and cash, etc. for all household members; opening and closing of bank accounts. (Includes joint ownership of any asset with spouse, parents, children, etc.)
  (Note: This is not required for CHIP, PCN, UPP, Child or Family Medicaid unless you pay a spenddown.)

- **Changes in Insurance Coverage**
  Gaining or losing health insurance coverage or changing the health insurance premium or plan. You must also report accidents or injuries which may be payable by a third party.

- **Changes in Expenses Paid**
  Changes in child care expense, shelter or utility costs, or support payments.
  (Note: This is not required for CHIP, PCN and UPP.)

FOR CHILD OR FAMILY MEDICAID, CHIP, UPP, OR PCN, YOU MUST ALSO REPORT:

- **Changes in Tax Filing Status or Number of Dependents Claimed on Your Taxes**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Earnings of a Child**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Student Status of a Child**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Access to Health Insurance Coverage**
  Gaining access to coverage under an employer sponsored health insurance plan, COBRA, Veteran's Administration, or Medicare. For PCN, this also includes health plans offered by a college/university.
  (Note: This is only required for CHIP, PCN and UPP.)

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ATTACHMENT A

American Indian or Alaska Native Family Member (AI/AN)

Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your application. If you have more people to include, make a copy of this page and attach it to your application.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN Person 1	AI/AN Person 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐Yes If yes, tribe name: _____ ☐No	☐Yes If yes, tribe name: _____ ☐No
3. Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐Yes ☐No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Yes ☐No	☐Yes ☐No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Yes ☐No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian Trust Land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	Amount: $_____ How often: _____	Amount: $_____ How often: _____

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ATTACHMENT B

Information About Your Dependents That Are Not Living With You

Complete this attachment for all dependents that ARE NOT living with you, but are claimed on your tax return. If you have more dependents that are not living with you, but are claimed on your tax return, please make a copy of this page and attach it to your application.

A. GENERAL INFORMATION

Complete the following chart for your dependent:

Name of Dependent (first, m.i., last)	Relationship to You	Date of Birth (mm/dd/yy)	Sex (f/m)	SSN# (optional)

☐Yes ☐No 1. Is your dependent currently pregnant or has been pregnant in the last 3 months?
If yes, due date: _____ How many babies are expected during the pregnancy? _____

B. INCOME

☐Yes ☐No 1. Does your dependent have earned income? If yes, complete the chart below:

Employer Name, Address and Phone#	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (tips, bonus, commission, etc.)
	/			

☐Yes ☐No 2. Does your dependent have self-employment income? If yes, list any self-employment income received.

Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	% Company Owned	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. In the past year, did your dependent change jobs, stop working or start working fewer hours?

☐Yes ☐No 4. Does your dependent have/receive any of the following? Check all that apply.

☐Unemployment $_____ How Often: _____
☐Pensions $_____ How Often: _____
☐Social Security $_____ How Often: _____
☐Alimony Received $_____ How Often: _____
☐Retirement Accts. $_____ How Often: _____
☐Net Farming/Fishing $_____ How Often: _____
☐Net Rental/Royalty $_____ How Often: _____
☐Other Income $_____ How Often: _____
Type: _____

C. DEDUCTIONS

Check all that apply, and give the amount and how often your dependent pays it. If your dependent pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *(Note: You should not include a cost already considered in your answer to net self-employment income.)*

☐Alimony Paid $_____ How Often: _____
☐Student Loan Interest $_____ How Often: _____
☐Other Deductions $_____ How Often: _____
Type: _____

D. YEARLY INCOME

Complete only if your dependent's income changes from month to month.

Total income THIS year: _____ Total income NEXT year: _____
(If you think it will be different)

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ATTACHMENT C

Employer's Health Insurance Information

You will need your employer or company's Human Resources representative to complete this form. Complete this form for each employed household member. You may copy this form. If you need more time to finish this form, please send us the rest of the application so that we can look at your application as soon as possible. However, in some situations, we will need the information from this form to help determine your eligibility. If you have questions regarding this form, please call 1-866-435-7414.

A. GENERAL INFORMATION

Employee Information

Employee Name: _____ Employee SSN#: _____
(first, m.i., last)

Employer Information

Employer Name: _____

EIN#: _____ Phone#: _____

Address: _____
street apt.# city state zip

Who can we contact about employee health coverage at this job?

Contact Name: _____

Phone#: _____ E-mail address: _____

☐Yes ☐No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐Yes ☐No 2. Is your health insurance a state employee benefit plan?

☐Yes ☐No 3. Is your health insurance offered through Avenue H?

☐Yes ☐No 4. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy)_____

☐Yes ☐No 5. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled: _____
_____

☐Yes ☐No 6. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy)_____

☐Yes ☐No 7. Does the employer offer a health plan that meets the *minimum value standard?

8. For the lowest-cost plan that meets the *minimum value standard offered only to employee (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:
a. How much would the employee have to pay in premiums for that plan? $_____
b. How often? ☐weekly ☐every 2 weeks ☐twice a month ☐quarterly ☐yearly

☐Yes ☐No 9. Do you know what change the employer will make for the new plan year? If yes, complete the following:
☐Employer won't offer health insurance
☐Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.)
a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐weekly ☐every 2 weeks ☐twice a month ☐quarterly ☐yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

B. EMPLOYER'S LEAST EXPENSIVE PLAN OR AVENUE H DEFAULT PLAN

Questions below refer to the **employer's least expensive plan** or the **Avenue H Default Plan.**

☐Yes ☐No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy)_____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + Spouse	$	
Employee + Child	$	
Family	$	

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

C. EMPLOYEE'S HEALTH PLAN CHOICE

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: _____

2. Policy number, if known: _____

☐Yes ☐No 3. Is the deductible $2,500 or less per individual?

☐Yes ☐No 4. Is the lifetime maximum benefit $1,000,000 or more?

☐Yes ☐No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)
☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐Yes ☐No 7. Does the plan cover abortion services?
If yes, under what circumstances:
☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
☐ Other, please describe:_____

8. Complete this chart only if it is different from the chart in Section B. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + Spouse	$	
Employee + Child	$	
Family	$	

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

☐Yes ☐No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):_____

D. SIGNATURE

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone#: _____

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245

Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717

ATTACHMENT D
Authorization to Disclose Medical Information

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

_____ _____ ____/____/____
Customer Name | Case # | Date of Birth

I, _____, hereby give _____the authority to:
Name of Customer or Authorized Representative | Name of Individual or Organization

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:
- The following date: _____; or
- The medical application is denied*; or
- 30 days from the month the medical program is closed*.

**If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.*

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

Address of Authorized Representative: _____

Phone Number of Authorized Representative: _____

- I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.
- I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm
- I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.
- I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.
- I understand that once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
  Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.
- By signing this form, I acknowledge I have been provided a copy of this signed authorization.

_____ _____
Signature of Customer, Legal Guardian, or Authorized Representative | Date

If signed by other than the customer, description of authority to serve:

_____

2016

HOSPITAL PRESUMPTIVE ELIGIBILTY
Training Manual

UTAH DEPARTMENT OF HEALTH
MEDICAID
A Bridge to Wellness for Utah's Vulnerable

With Presumptive Eligibility (PE), an individual can be temporarily enrolled in Medicaid if it appears they are eligible.

State of Utah

11/1/2016

Hospital Presumptive Eligibility (HPE) Provider Manual

Table of Contents

PART 1 – General Information

Section 1: What Is Presumptive Eligibility (PE)?

- PE is a temporary Medicaid program that bases eligibility on preliminary information to make an individual 'presumptively' eligible. There are two PE programs that are administered throughout the state: Hospital Presumptive Eligibility (HPE) and Baby Your Baby (BYB).
- The two departments that oversee the programs are the Utah Department of Health (DOH) and the Department of Workforce Services (DWS). DOH is responsible for policy, training, procedures and accuracy of the PE programs, while DWS is responsible for the eligibility systems and ongoing Medicaid coverage.
- DOH issues Memorandum of Agreements (MOA) between DOH and hospitals throughout the state to administer the HPE program. Only hospital staff who are trained in the HPE process by DOH can determine HPE eligibility.
- Applicants can apply for HPE through any qualified hospital.

Section 2: Contact Information

Dave Baldwin
Policy Specialist
Phone: (801) 538-7020
Fax: (801) 538-6952
hpepolicy@utah.gov
Utah Department of Health/ Bureau of Eligibility Policy
PO Box 143107
Salt Lake City, UT 84114-3107

OR

Laura Belgique (back up)
Program Specialist
Phone: (801) 538-6241
Fax: (801) 538-6952
hpepolicy@utah.gov
Utah Department of Health/ Bureau of Eligibility Policy
PO Box 143107
Salt Lake City, UT 84114-3107

Section 3: Resources

- For questions regarding policy, procedure, trainings or to order applications or other documents email hpepolicy@utah.gov.
- **Submit completed applications** including all pages to DWS at hospitalPE@utah.gov (This includes approved and denied applications.)
- To verify client eligibility:
  - Eligibility Lookup Tool at: https://medicaid.utah.gov/eligibility
  - Call Medicaid at (801)538-6155 or 1-800-662-9651.
  - Key in the client ID number and use the HPE determination date as the date of the medical service received. If the applicant is eligible, the system will give the medical program type, health plan, co-pay, mental health coverage information, and TPL information.

PART 2 Policies and Procedures

Section 1: Terms of Agreement

- A hospital must inform DOH that it intends to make HPE determinations and that it agrees to follow the State's policies and procedures as outlined in the MOA and the HPE Training Manual. DOH will provide hospitals with information on all policies and procedures related to HPE.
- A hospital must make HPE determinations in accordance with DOH's policies and procedures. If a hospital is not making HPE determinations in accordance with DOH's policies and procedures, DOH will provide the hospital with additional training or other forms of corrective action before disqualifying the hospital.
- The hospital must notify DOH of all new staff that will determine eligibility,
- The hospital must report within five business days when any HPE staff changes job responsibilities or terminates employment.
- All staff must receive HPE training directly from DOH prior to determining presumptive eligibility.
- Eligibility determinations may only be performed by staff employed by the hospital at the location in which they work and determine eligibility.
- A hospital must comply with the proficiency standard set by DOH. DOH has set standard at an 85 percent accuracy rate on HPE decisions. Accuracy is based on the application and application process. Determinations are based on the information provided by the applicant.
- The hospital may not prescreen potential applicants. However, the hospital may describe the eligibility qualifications to individuals who inquire about the program.

Section 2: Services and Payment

- HPE covers an array of Medicaid eligible services that may include medication, lab work, inpatient and outpatient care.
- Pregnant women HPE covers pregnancy-related ambulatory services including pharmacy and dental. This includes prenatal visits, prenatal lab tests, ultrasounds, prenatal vitamins. **It does not cover labor and delivery of the baby**.
- Hospitals will be paid at regular Medicaid rates for covered services. For questions regarding covered services, call Medicaid Information Line at (800) 662-9651.
- During the HPE period, the applicant will also be able to receive treatment from other Medicaid providers after they leave the hospital.
- Payments for covered services are guaranteed to a hospital during an individual's presumptive eligibility period, even if the person fails to complete the full Medicaid application or is ultimately determined to be ineligible for ongoing Medicaid. Money will not recouped from the hospital for services rendered during the HPE period.

Section 3: Confidentiality

- All confidential information must be safeguarded from unauthorized disclosure and use. Staff who fail to safeguard confidential information may be subject to both civil and criminal penalties.
- Confidential information includes:
  - Identifying information, such as names, addresses, telephone numbers, social security numbers, etc.
  - Information used to determine eligibility, such as income, assets, medical reports and data, names of persons obligated to provide financial and medical support, etc.
  - Information about benefits and medical services provided to individual recipients.
- Information that cannot be identified to particular applicants and recipients is not confidential information. For example, information stating the total number of HPE recipients is not confidential information because no one person can be identified by the general information.
- The hospital shall only access, use, or disclose data solely for the purposes of determining HPE.
- The hospital shall implement and maintain administrative, technical, and physical safeguards necessary to protect the confidentiality of the data and to prevent any unauthorized use or access. Any and all transmission or exchange of data and electronic records shall take place via secure means.

Section 4: Fraud, Waste and Abuse

- To report suspected fraud, contact the DWS Information Fraud Hotline at (800)955-2210 or via email at wsinv@utah.gov.
- What you need to know when reporting fraud, waste or abuse:
  - ➢ It is helpful if you can provide any of the following information when reporting fraud, waste or abuse of the HPE Program:
    - Provider or recipient name
    - Date of birth
    - Address
    - Phone number
    - Medicaid ID or SSN
    - Other details about what you suspect may be happening that appears to be wrong
  - ➢ You may remain anonymous when reporting suspected fraud
  - ➢ You may be requested to provide your name so that the investigator can contact you if there are questions regarding your referral. However, you may request that your name is not used in conjunction with the case.
  - ➢ You may find more information on reporting fraud, waste or abuse at: http://hldev/mpi/forms/recipient.php

Section 5: Completing the Application

- Always use the most current application form. DOH will supply hospitals with applications and receipts.
- Self-declaration is used for all factors of eligibility.
- If an applicant is unable to complete the application, they may assign an authorized representative to apply on their behalf.
  - ➢ Hospitals cannot require individuals to assign the hospital as their authorized representative.
  - ➢ In general, the person who signs the application must be someone who can answer the questions on the application.
  - ➢ If an applicant is unable to write, he/she must make a mark on the application and have at least one witness to the signature.
- All required sections, as stated on the front page of the application, must be completed.
- If the applicant completes Section D of the application, the income amount must match the income reported in Section K.
- Applications must be signed and dated or the application is incomplete. Unless a minor is living independently, a parent or responsible adult must sign the application.

- Coverage cannot begin before the date the application is signed and dated. If a determination is made after the application date, the start date for coverage is the date HPE is approved by the hospital.
- Applications must be sent to DWS within five business days from the date of the HPE determination.
- If an application is incomplete, DWS will send the application back and the hospital will have 2 business days to correct the application (this may require contacting the client) and return it to DWS. If the corrected application is not returned within those 2 days, the application will be denied.
- Individuals can still receive HPE, even if they have other health insurance.

Section 6: Eligibility Criteria

Self-declaration is used for all eligibility criteria. Compare the responses on the application to the eligibility criteria listed in this section. Individuals who do not meet the criteria listed below are not eligible for HPE.

- Be a Utah resident.
- Be a U.S. Citizen or National.
  - Individuals born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands are U.S. citizens.
  - Individuals born in American Samoa or Swain's Islands are Nationals and treated in the same manner as a U.S. citizen.
- Be a Qualified Non-Citizen.
  - The following qualified non-citizens are barred from receiving HPE for a period of five years from the date they became a qualified non-citizen:
    - Lawful permanent residents (LPR).
    - Individuals granted conditional entry prior to April 1, 1980.
    - Battered individuals, this includes the individuals spouse, children and parents.
    - Individuals paroled into the U.S. for at least a year.
  - The following qualified non-citizens <u>are not</u> barred from receiving HPE (even after becoming an LPR):
    - A child under age 19 that meets any qualified non-citizen status.
    - Admitted as a refugee under Section 207 or asylum under Section 208 of the Immigration and Nationality Act (INA).

- Deportation has been withheld under section 243(h) of the INA (prior to September 30, 1996) or under section 241(b)(3) of the INA (after September 30, 1996).
- Granted status as a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.
- Admitted as an Amerasian immigrant.
- An American Indian born in Canada who is at least one-half American Indian or a member of federally recognized Indian tribe.
- Veterans who received an honorable discharge or a military service member on active duty in the Armed Forces of the U.S. A person on active duty for training does not qualify under this category.
- A spouse or unmarried dependent child of a veteran or active duty service member as described above.
- The surviving spouse of a deceased veteran or service member, provided the spouse has not remarried and the marriage fulfills the following requirements:
  - Married for at least one year;
  - Married before the end of a fifteen-year time span following the end of the period of military service in which the injury or disease was incurred or aggravated; or
  - Married for any period if a child was born of the marriage or was born before the marriage.
- Victims of trafficking.
- Iraqi and Afghan Special Immigrants.
- Non-citizens receiving SSI.

- Be a child under the age of 19 and legally residing in the U.S. The following individuals are considered legally residing:
  - A qualified non-citizen (see above)
  - Non-citizens who:
    - Has a valid non-immigrant status (for example, student visas, worker visas, etc.)
    - Has been paroled into the United States, for less than 1 year. (except if paroled for prosecution, deferred inspection or pending removal proceedings)
    - Belongs to one of the following classes:
      - Currently in temporary resident status;
      - Currently under Temporary Protected Status (TPS) (and pending applicants for TPS who have been granted employment authorization;
      - Have been granted employment authorization;
      - Family Unity beneficiaries;

    - Currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
    - Currently in deferred action status. This does not include Deferred Action for Childhood Arrivals (DACA or 'dreamers'); or
    - Granted an administrative stay of removal
    - Individuals whose visa petition has been approved and is pending application for adjustment of status.
  - Is a pending applicant for asylum or for withholding of removal or under the Convention Against Torture who has been granted employment authorization, or is an applicant under the age of 14 and has had an application pending for at least 180 days.
  - Been granted withholding of removal under the Convention Against Torture.
  - Pending an application for Special Immigrant Juvenile status.
  - Lawfully present in American Samoa under the immigration laws of American Samoa.
- Except for pregnant woman PE, an individual can only receive HPE one time in the current calendar year. Woman can receive pregnant woman HPE one time during each pregnancy.
- Cannot be open for Medicaid, CHIP, UPP, PCN, BYB, or Medicaid with a spenddown, even if the spenddown has not been paid.
- Must not have been denial for Medicaid, CHIP, UPP or PCN within the past 30 days, unless household circumstances have changed. If the individual was denied for Medicaid because of income and now they report a decrease in income; determine HPE eligibility.
- Be at or under the income limit for the specific HPE program. The income limit is based on household size. See section 9 & 10 to determine the household size and income.
- There is no asset test.

Section 7: Medicaid Programs and Hierarchy

A PE determination can only be completed on certain Medicaid programs. Do not complete a determination on individuals in the household who are not wanting HPE coverage. The programs which a determination can be complete on and the order of hierarchy starting with Child Medicaid are listed below:

- Child 0-5 (CM 0-5)
- Child 6-18 (CM 6-18)
- Parent/Caretaker Relative (PCR)
- Pregnant woman (PW)
- Former Foster Care (FC)

A few examples of incorrect determinations:

- PCR for a child under 19
- CM 6-18 for a child under age 6
- PW for a male
- CHIP, PCN, Family or Emergency Medicaid for any individual

Section 8: Basic Program Requirements:

❖ Child Medicaid Age 0-5

- Income limit: 139% of the Federal Poverty Level (FPL).
- Can receive eligibility through the month in which they turn age 6.
- Parent(s) income is countable.
- A child does not have to live with a parent.

❖ Child Medicaid Age 6-18

- Income limit: 133% of FPL.
- Can receive eligibility through the month in which they turn age 19.
- Parent(s) income is countable.
- A child does not have to live with a parent.

❖ Parent/Caretaker Relative (PCR) Age 19-64

- Income limit: See income chart in Appendix 1.
- Must be age 19 or older, and can receive eligibility through the month in which they turn age 65.
- Must have an eligible child.
    - Household must include a child that is either under 18 or child age 18 who is a full time student, and expected to graduate before the age of 19.
    - If there are no other eligible children in the household, an unborn can count as an eligible child if the woman is in her 3rd trimester (If she is not in her 3rd trimester determine if she qualifies for PW).
- Deprivation of Support must exist.
    - Deprivation of support exists if the household has:
        - A parent who is deceased.
        - A parent who is incapacitated.
        - A parent who is unemployed or employed less than 100 hours per month.
        - A parent who is absent.

❖ Pregnant Woman

- Income limit: 139% of FPL.
- The woman must be pregnant on the day of approval for HPE.

- If age 19 or older and lives with her parent(s), her parent's income is not countable.
- If under age 19 and living with her parent(s), her parents' income is countable.
- Only covers pregnancy related outpatient services. Labor and delivery are not covered under PW.

NOTE: Due to the hierarchy of CM and PCR to PW, it is possible that a pregnant woman is determined eligible for CM or PCR. CM and PCR cover labor and delivery.

❖ Former Foster Care Individuals

- Age 18 to 26. Eligibility runs through the month they turn age 26.
- The individual was receiving Medicaid when they aged out of foster care in any state on or after their 18th birthday.
- Individual was in the custody of DCFS, DHS or an American Indian Tribe when foster care ended. Persons in the custody of Juvenile Justice Services are not eligible.
- There is no income test.
- Must not be eligible for CM, PCR or PW.

Section 9: Determining Household Size

With the exception of Former Foster Care, household size is determined by relationship and living arrangements. Do not include in the household size individuals who do not live with the person needing HPE coverage.

❖ Under Age 19

Include the following in the household size:

- The individual
- The individual's children
- If pregnant, the number of unborn children of the individual
- Legal spouse
- Parent(s) or step-parent(s)
- Any sibling under the age of 19

Note: Do not include adults in a child's household size if they are not a parent of that child, such as a grandparent or aunt/uncle.

❖ Over Age 19

Include the following in the household size:

- The individual
- If pregnant, the number of unborn children of the individual
- Legal spouse
- Children or step-children under the age of 19

❖ Former Foster Care

Include the following in the household size:

- The individual (always a household size of 1)

Example: Laurie (18) who is pregnant, lives with her boyfriend George and her parents Dave and Linda. She also has two siblings Gina (20) who is also pregnant and her brother Lane (15). The household size for Laurie is 5. George is not included as they are not married and Gina is also not included as she is over the age of 18.

Section 10: Income

❖ General Rules

- Only the income of a parent is countable, unless a child under age 19 is not living with a parent, then that child's income will count.
- For earned income, count the gross income, before taxes and deductions.
- For self-employment, count the net income after business expenses.
- Applicants must self-declare income in Section K (even if income is zero).
- Applicant must declare which income is correct if there is a discrepancy in income posted in Sections D and K.
- The following apply for the income of a child who is under age 19:
  - Not countable if living with a parent
  - Countable if not living with a parent
- Income of a sibling is not countable
- Income of a guardian or adult who is not the parent is not countable.
- FC does not have an income limit.
- The following apply for American Indian income:
  - Revenues from tribal ran gambling are countable
  - Tribal benefits are not countable
- The following income types are not countable:
  - Educational income
  - Veteran's income
  - Child support

❖ Determining Income

- **Determining Income Without Check Stubs**

  To determine monthly income without check stubs, you will need to know how often the individual is paid, how many hours a week they work and their hourly rate.

  - **Paid "Weekly" or "Every Other Week"**

- Multiply hours worked each week by the hourly rate. This will give you their gross weekly income.
- Multiply gross weekly income by 4.3. This will give you their gross monthly income.

Example: Individual works 32 hours a week at $11.25 an hour.

- 32 hours per week 'X' $11.25 an hour = $360 (weekly income).
- $360 'X' 4.3 = $1548 (monthly income).

➢ **Paid "Twice a Month" or "Monthly"**

If an individual is paid twice a month or monthly, you will need to use 172 hour chart (appendix 3) to determine the monthly income.

- Using the 172 hour chart, find the weekly hours the individual states they work in the column on the left. This will determine the monthly hours as shown in the right column.
- Multiply the monthly hours by the hourly rate. This will give you their gross monthly income.

Example: Individual works 29 hours a week at $10.25 an hour.

- 29 weekly hours = 126 monthly hours.
- 126 monthly hours 'X' $10.25 = 1,291.50 (monthly income)

- **Determining Income Using Check Stubs**

Check stubs are not required. However, if an applicant provides you with check stubs determine income as follows:

➢ **Paid "Weekly"**

- Multiply gross amount on the check stub by 4.3.
  - Check stub shows gross income of $512.50. Multiply $512.50 by 4.3 = $2203.75 (monthly income).

➢ **Paid "Every Two Weeks"**

- Multiply the gross paycheck amount by 2.15
  - Check stub shows gross income of $412.55. Multiply $412.55 by 2.15 = $886.98 (monthly income).

➢ **Paid "Twice a Month"**

- Multiply the gross paycheck amount by 2.
  - Check stub shows gross income of $680.01. Multiply $680.01 by 2 = $1360.02 (monthly income).

➢ **Paid "Monthly"**

- The gross amount on check is the gross monthly income.

Section 11: What Happens After An Eligibility Determination?

☑ Complete the cover sheet for presumptive eligibility for approved and denied applicants. Make sure to complete all fields and include the denial reason if the applicant is not eligible.

Possible denial reasons are as follows:

1. **Not a U.S. citizen or qualified non-citizen**
2. **Not a Utah resident**
3. **Current CHIP, UPP, PCN, or Medicaid recipient**
4. **Medicaid denial in the past 30 days**
5. **Already received HPE for the current pregnancy**
6. **Over the income limit**
7. **No available HPE program**
8. **Not enough information to determine HPE**
9. **Issued HPE in the current calendar year**
10. **No deprivation**

☑ If eligible for HPE, complete the "Presumptive Eligibility Receipt" and give it to the applicant.

☑ Hospital submits the application and e-mails it to DWS at hospitalPE@utah.gov

- The application must be sent within 5 working days.
- **IMPORTANT:**
  - If the application is not submitted within 5 working days of the decision, the determination is void and HPE will not be issued.
  - If the application is incomplete DWS will contact the hospital for additional information. The hospital must respond to DWS within 2 business days or HPE will not be issued. (Business days are Monday – Friday 8am to 5pm excluding holidays)
  - Applications will be used to determine regular Medicaid unless the applicant opts out.
  - Only submit one application per email.
  - Shred the paper application.

☑ The entire application must be sent with a completed cover page. DWS will enter the HPE decision into their eligibility system and will send the approval/denial notice and medical card (if approved for HPE).

☑ A new card will not be issued if the applicant is approved for ongoing Medicaid. The applicant will continue to use the card issued for HPE.

- Most Medicaid programs under HPE provide the same medical coverage as ongoing Medicaid.

  Exception: "Pregnant Woman" program only covers pregnancy related outpatient services. Delivery and inpatient services are not covered.

☑ HPE coverage will continue until DWS makes a decision for ongoing Medicaid. The day the decision is made for ongoing Medicaid, is the same day the HPE program will end.

☑ If the applicant opted out for ongoing Medicaid, HPE coverage will end on the last day of the month following the month HPE was approved.

Section 12: CHECK LIST

Complete the following:

- ☑ Make sure all required HPE sections of the application are complete including a signature.
- ☑ Help the customer complete the application if needed.

  Note: Although the applicant is only required to complete the questions for HPE, you must submit the entire application. Completing the entire Medicaid application may expedite eligibility for ongoing medical coverage.
- ☑ Send the entire application to hospitalPE@utah.gov within 5 business days. This includes both approved and denied applications.
- ☑ If eligible for HPE, complete a "Presumptive Eligibility Receipt" and give to the applicant.
- ☑ Shred the paper application.

Educate the applicant on the following:

- ☑ Inform the applicant they can use their HPE coverage with any Utah Medicaid provider.
- ☑ Inform the applicant to stop using HPE benefits if they are denied for ongoing Medicaid.
  - If the applicant continues to use HPE coverage after being denied for ongoing medical assistance, they may be responsible to pay back any benefits received.
- ☑ Inform the applicant if they are approved for ongoing Medicaid, they will continue to use the same wallet-sized card that was issued for HPE.
- ☑ Inform the applicant that DWS may contact them for additional information for ongoing eligibility (if they did not opt out ongoing medical).
- ☑ Inform anyone approved for the HPE "Pregnant Woman" program that only pregnancy related outpatient services are covered. Labor and Delivery are not a covered service.
- ☑ Inform the applicant that they can only receive HPE once per calendar year even if they didn't use the benefits.

  Exception: A pregnant woman can receive presumptive eligibility once per pregnancy including HPE and BYB.

PART 3 APPENDICES

Appendix 1: INCOME CHART

Effective March 1, 2016- February 28, 2017

Household Size	Parent/Caretaker Relative (PCR) Age 19-64	Pregnant Woman Under Age 65 & Child Medicaid Age 0-5	Child Medicaid Age 6-18	Former Foster Care Individuals Age 18-26
		139% FPL	133% FPL	No Income Limit
1	$438	$1377	$1317	
2	$544	$1856	$1776	
3	$678	$2336	$2235	
4	$797	$2815	$2694	
5	$912	$3295	$3153	
6	$1012	$3774	$3611	
7	$1072	$4255	$4071	
8	$1132	$4737	$4532	
9	$1196	$5219	$4994	
10	$1257	$5701	$5455	

Appendix 2: 172 Hour Chart

Use this chart when an applicant is paid "monthly" or "twice per month".

When using the 172 hour chart, find the weekly hours the client states they work in the column on the left. This will determine the monthly hours as shown in the right column in order to calculate the monthly gross income.

Average Hours Worked Per Week	Monthly Hours
40	172
39	169
38	163
37	160
36	155
35	151
34	146
33	143
32	138
31	134
30	129
29	126
28	120
27	117
26	112
25	108
24	103
23	100
22	95
21	91
20	86
19	83
18	77
17	74
16	69
15	65
14	60
13	57
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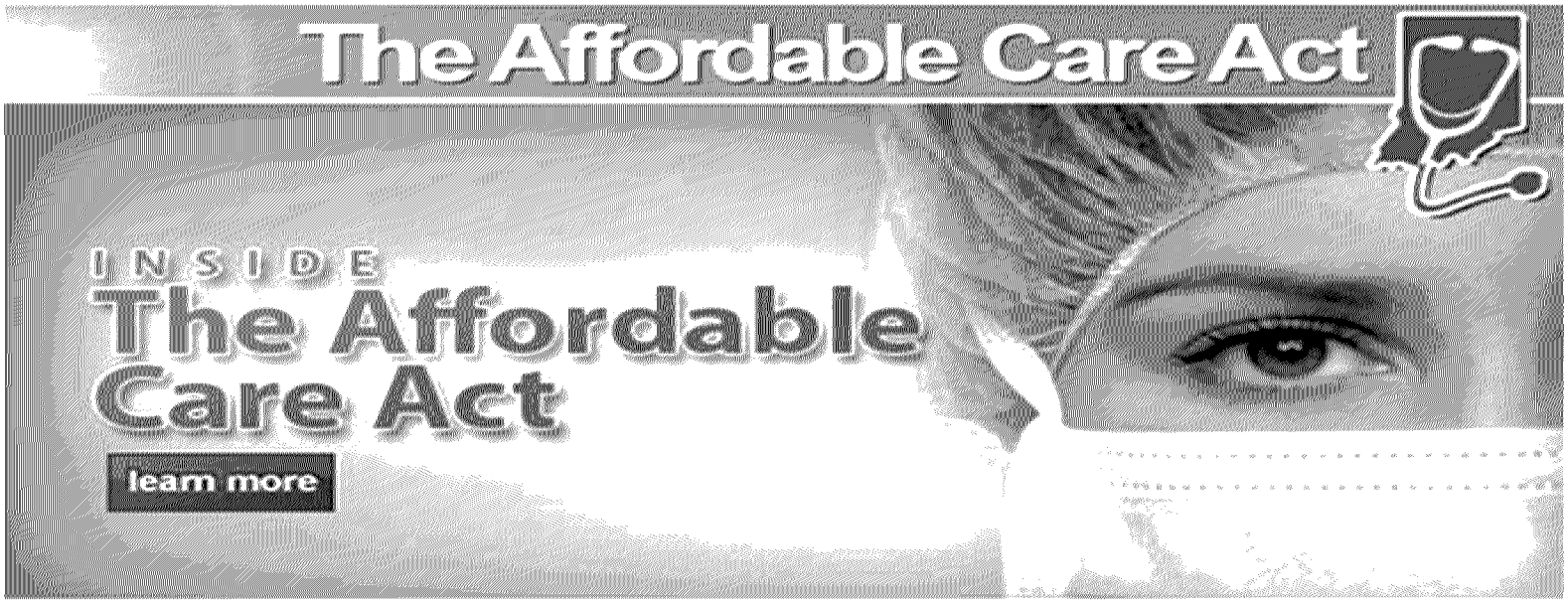
6	26
5	22
4	17
3	14
2	9
1	5



HOSPITAL PRESUMPTIVE ELIGIBILITY AT A HOSPITAL NEAR YOU

UTAH DEPARTMENT OF HEALTH

July 1, 2016

What is Hospital Presumptive Eligibility (HPE)?

- Temporary medical coverage
- Assures timely access to care while a final eligibility determination is made for ongoing Medicaid
- Client statement is used for all factors of eligibility
- Hospital eligibility decision accepted

Rules Hospitals Must Comply With

- Follow the State's policies and procedures related to HPE
- Make HPE determinations in accordance with policies and procedures
- Must complete training with UDOH prior to determining presumptive eligibility
- Must report all changes in staff within five business days
- Meet proficiency standards and meet a standard 85 percent accuracy rate
- Only individuals employed by the hospital may determine presumptive eligibility

Confidentiality

- Safeguard Confidential Information
- Confidential information includes identifying information about clients and recipients as well as the benefits and medical services provided etc.

Completing the Application

- Use the most current application available
- Ensure all the required questions are completed by the client
  - All the required questions are identified in the section "What Do I Need to Do Next?" on the cover page of the application
- For ongoing Medicaid, completing the remaining questions may expedite the application process
  - A client can Opt Out of applying for ongoing Medicaid benefits, while still applying for HPE
- Ensure the client signs and dates the application

Basic Eligibility Requirements

- Eligibility begins on the date of approval
- A signature is required by the client or authorized representative
- If the client is a minor, the client's parent, legal guardian, or representative must sign the application
- Depending on the program other requirements must be met

Basic Eligibility Requirements

- U.S. citizen or qualified alien
- Utah resident
- Limit of one HPE period per calendar year (Jan-Dec)
  - With the exception of a pregnant woman. A pregnant woman can receive PE once per pregnancy
- Must not have received a denial for Medicaid, CHIP, UPP, or PCN within the past 30 days
  - (unless there is a change in circumstances)
- Must not currently be receiving Utah Medicaid, CHIP, UPP, or PCN or be approved for Medicaid with a spend down
- Be at or below the income limit for HPE program

Hierarchy of HPE Program Types

- When deciding which program category to approve for an individual, use the following Hierarchy:
  - Child 0-5
  - Child 6-18
  - Parent/Caretaker Relative 19-64
  - Pregnant Woman
  - Former Foster Care Individual 18-26

Child Medicaid Age 0-5
Eligibility Requirements

- Income under 139% FPL
- A child can receive eligibility through the month in which they turn 6
- If they live with a parent, the parent's income counts
- A child does not need to live with a parent to receive PE

Child Medicaid Age 6-18
Eligibility requirements

- Income under 133% FPL
- A child can receive eligibility through the month in which they turn 18
- If they live with a parent, the parents' income counts
- A child does not need to live with a parent to receive PE

Parent/Caretaker Relative Medicaid

Eligibility Requirements

- Must meet the age limit
  - A person must be at least 19
- Must meet the income limit
  - See income chart for income limits
- Household must include a child that is under age 18 or age 18 and a full time student expecting to graduate before age 19
- Deprivation of support must exist due to a parent being absent, deceased, incapacitated, or underemployed

Pregnant Woman Medicaid Eligibility Requirements

- Income under 139% FPL
- Must be pregnant at date of application
- If under 19 years of age and living with a parent, the parents' income counts
- Limit of one HPE period per pregnancy
- Program covers pregnancy related outpatient services only.
- Labor and delivery are not covered

Former Foster Care Individuals
Eligibility Requirements

- No income test
- Must not be eligible for another HPE program
- Age 18-through month they turn 26
- Must have been on Medicaid when they aged out of Foster Care or in the custody of the state or an indian tribe.
- Persons in the custody of Juvenile Justice Services are not eligible

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Determining Household Size

If the individual is 19 or older, include the following:	If the individual is under age 19, include the following:
The individual	The individual
Legal spouse	Legal spouse
Number of unborn children	Number of unborn children
Individual's children or step children under age 19	Individual's siblings who are under the age 19
	A parent

- Only include people in the household size that live together
- Only the individual will be included in the household size for Former Foster Care – Will always be a household size of 1

Whose Income to Count

- Income of a parent is countable
- Income of a guardian or adult who is not a parent, is not countable
- The following apply for individuals under age 19 with income:
  - Not countable if living with a parent
  - Countable if not living with a parent
  - Income of a sibling is not countable

Exempt Sources of Income

- ❑ Child support
- ❑ Veterans
- ❑ Educational
- ❑ Tribal benefits

Determining Monthly Gross Income

- Applicants must declare their monthly income
- Assist client in determining monthly income when requested
- Count the household income of each adult included in the household size such as:
  - Gross earned income (wages, salary and tips)
  - Net self-employment income or business income
  - Social Security benefits
  - Unemployment Benefits
  - Alimony
  - Interest and dividends
  - Rental income

Determining Income Using Check Stubs

First determine how often the individual is paid:

- Weekly
- Every other week
- Twice a month
- Monthly

Determining Income Using Check Stubs

When paid weekly:

- Multiply gross income listed on check stub by 4.3
- Example: Individual's check stub indicates $300
    1. *Multiply $300 x 4.3=**$1,290***

Determining Income Using Check Stubs

When paid every other week:

- Multiply gross income by 2.15
- Example: Individual's paycheck stub indicates $502.00

    1. *Multiply $502 x 2.15 =* ***$1075***

Determining Income Using Check Stubs

When paid twice a month:

- Multiply gross income by 2
- Example: Individual's paycheck stub indicates $1000

    1. *Multiply $1000 x 2 =* ***$2000***

Determining Income Using Check Stubs

When paid monthly:

- The gross amount of the check is the monthly income

Determining Income Without Check Stubs

Determine the following:

- How often they are paid
- How many hours do they work a week
- How much they are paid per hour

Determining Income Without Check Stubs

When paid weekly or every other week:

- Determine weekly gross income and then multiply that amount by 4.3

- Client works 32 hours per week and makes $11.25 per hour

Multiply weekly wage by 4.3

1. Multiply 32 hours by $11.25 = $360 weekly gross income
2. Take the weekly gross income of $360 and multiply by 4.3
3. Monthly Gross Income **= $1548**

Determining Income Without Check Stubs

When paid twice a month or monthly:

You **MUST** use the 172 hour chart in your manual to determine the monthly hours

- Client works 29 hours per week
- Client is paid $10.25 per hour

29 weekly hours equals 126 monthly hours

- *Multiply 126 monthly hours by $10.25*
- *Monthly countable income =* ***$1291.50***

172 Hour Chart

Weekly Hours Worked	Monthly Hours Worked
40	172
39	169
38	163
37	160
36	155
35	151
34	146
33	143
32	138
31	134
30	129
29	126
28	120
27	117
26 weekly hours =	112 monthly hours
25	108
24	103

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Next Steps

- Review factors of eligibility, such as citizenship and residency
- Determine the household size and income, and compare to income limits for the HPE program(s) your are determining eligibility for
- Approve or deny the application and indicate decision and what programs on the cover sheet
- If denied, complete denial reason on cover shett
- Scan and email the application with the completed coversheet to the Department of Workforce Services within 5 business days of your determination
  - When sending via email, send one application per submission.
- Shred the application
- If an email is received from DWS asking questions, a response is required within 2 business days

Contact Information

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