ARKANSAS REGISTER

Transmittal Sheet

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Secretary of State
State Capitol Room 017
Little Rock, AR 72201-1094

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Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Joie Wallis

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CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance With Act 434 of 1967 As Amended.

Signature

Director, Division of County Operations
Title

4/24/97
Date

FILED
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SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

[X] Policy [ ] Form [ ] Policy Directive

Issuance Number MS 97-3

Medical Services Policy Manual

Issuance Date 04-01-97

From: Roy Hart, Director

Expiration Date Until Superseded

Subj: Revised Policy

Pages to be Removed,	Dated	Pages to be Added,	Dated
MS 2047-2047.2	8/1/94	MS 2047-2047.2	8/1/94
MS 2047.2-2047.3	4/1/96	MS 2047.2-2047.3	4/1/97
MS 2048.3-2048.4	4/1/96	MS 2048.3-2048.4	4/1/97
MS 2048.5-2048.6	8/1/94	MS 2048.5-2048.6	8/1/94
MS 2051.3-2051.4	4/1/96	MS 2051.3-2051.4	4/1/97
MS 2051.4-2051.5	1/1/95	MS 2051.4-2051.5	1/1/95
MS 2062.3-2062.4	4/1/96	MS 2062.3-2062.4	4/1/97
MS 2062.4-2062.6	8/1/94	MS 2062.4-2062.6	8/1/94
MS 5730-5740.1	4/1/96	MS 5730-5740.1	4/1/97
MS 5740.1-5740.2	5/1/94	MS 5740.1-5740.2	5/1/94

Summary of Changes

2047.2 #7 - The 1997 Federal Poverty Income Guidelines for QMB have been incorporated effective 4/1/97. Current Social Security benefits should be used and compared against the new QMB limits. Instructions for processing these cases will be issued under separate cover.

2048.3 #4 - Effective 4/1/97, the 1997 Federal Poverty Income Guidelines for QDWI have been incorporated.

2051.3 #7 - The 1997 Federal Poverty Income Guidelines have been incorporated for SMB effective 4/1/97. Current Social Security benefits should be compared to the new SMB income limits. Instructions for processing these cases will be issued under separate cover.

2062.3 - The 185 percent income limits for Transitional Medicaid have been changed to reflect the 1997 Federal Poverty Income Guidelines. These guidelines will be effective 4/1/97.

5730 - The 1997 Federal Poverty Income Guidelines have been incorporated for SOBRA income eligibility. These guidelines will be effective 4/1/97 at 133% for Women and children under age 6, 100% for children ages 6 up to age 14. (Re. 5740.2)

Inquiries to: Terri Wright, 682-8258
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2047 Qualified Medicare Beneficiaries Under the Medicare Catastrophic Coverage Act of 1988

Section 301 of Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, requires Medicaid buy-in of Medicare premiums and coverage of deductibles and coinsurance for Qualified Medicare Beneficiaries (QMBs) with income at or below specified percentages of the poverty level and resources at or below twice the SSI limit.

2047.1 Scope of Services

Qualified Medicare Beneficiaries under the Medicare Catastrophic Coverage Act are not eligible for the full range of Medicaid Services. QMBs are eligible only for payment of all Medicare premiums, deductibles, and coinsurance.

QMBs will not be eligible for any retroactive coverage as QMBs. Coverage of Medicare premiums, deductibles, and coinsurance will begin on the first of the month following the month of approval, where an individual is found eligible as a QMB.

Individuals who apply for coverage as QMBs and who have medical expenses in prior months may be considered in other Medicaid categories (including spend-down categories) for the retroactive coverage.

With the exception of spend-down categories, an individual may not be certified in a QMB category and in another Medicaid category for simultaneous periods. If an individual is eligible in a category other than QMB, he will be eligible for and receive the QMB benefits along with the other Medicaid benefits (Re MS 2047.8). If an individual could be eligible in either a QMB category or a non-QMB category, the individual should be approved in the non-QMB category. Example: An individual is eligible in both categories 41 and 48; the individual will be certified in category 41, but will receive full QMB benefits.

An individual may be approved for a spend-down and as a QMB for simultaneous periods. Example: An individual applies for QMB coverage and for other Medicaid categories on March 1 and has sufficient non-coverable medical bills for a spend-down period of March, April, and May. QMB coverage is approved on March 30. QMB coverage will begin April 1. For any concurrent months of QMB and spend-down eligibility, Medicare premiums may not be considered as a non-coverable medical expense.

2047.2 Eligibility Requirements

QMBs must meet the following eligibility requirements:

1. Categorical Relatedness: A QMB must be aged, blind, or disabled as specified in MS 3321 - 3323.

2. Medicare Part A Entitlement or Conditional Eligibility: A QMB must be entitled to or conditionally eligible for hospital benefits under Medicare Part A (Re. MS 2047.3). Entitled means that the individual has applied for, is eligible for, and is enrolled in Medicare Part A. Conditionally eligible means that an individual can be enrolled (entitled) for Part A Medicare only on the condition that he/she is eligible for QMB and, thus, eligible for the state Medicaid agency to pay the Part A premium as part of the QMB benefits.

3. Citizenship or Alien Status: A QMB must meet the citizenship/alien status requirement as specified in MS 3324.

4. Enumeration: A QMB must meet the Social Security Enumeration requirement as specified in MS 1358.

5. Residency: A QMB must be an Arkansas resident (Re. MS 2200).

6. Resources: A QMB's countable resources may equal but cannot exceed twice the current SSI limitations (Re. MS 3310, #5). The current QMB resource standards are as follows:

Individual	$4,000
Couple	$6,000

Countable Resources are determined according to LTC guidelines (Re. MS 3330-3337). There will be no penalty imposed for transfer of resources.

* 7. Income: The QMB's monthly countable income may equal but cannot exceed 100% percent of the 1997 Federal Poverty Level.

Effective 4/1/97, the monthly income limits are as follows:

Individual	$657.50
Couple	$884.17

Countable Income is determined according to LTC guidelines (Re. MS 3340-3348). In-Kind Support and Maintenance is considered in QMB determinations. For a couple, total monthly countable income will be compared to the couple's standard in each case. If only one spouse can be a QMB, then the procedures for deeming of income in MS 2111-2111.5 will apply.

Individuals applying for QMB coverage only will not be required to apply for SSI if their income is less than the SSI SPA. If an individual does not wish to be referred to SSA and does not want to be certified for full Medicaid benefits in a non-QMB category, he may be certified for QMB coverage only.

8. Mandatory Assignment of Rights to Medical Support/Third Party Liability: Re. MS 1350.

9. CSE Referrals for Minors With Absent Parents: Re. MS 1355.

2047.3 Medicare Part A Entitlement

A QMB must be entitled to or conditionally eligible for hospital insurance benefits under Medicare Part A. Medicare Part A beneficiaries include the following groups:

1. Persons age 65 or older who meet one of the following criteria:

   a. entitled to monthly Social Security benefits on the basis of covered work under the Social Security Act; or qualified Railroad Retirement beneficiaries; or

Verification that the individual's blindness or disability is continuing; that the individual's entitlement to SSA-DIB and Medicare Part A was lost solely due to SGA; that the individual has reenrolled for Medicare Part A; and the effective date of Medicare Part A coverage will be made by requesting the individual to provide any notices received from SSA. If the individual does not have the necessary verification, he/she will be instructed to obtain the needed verification from SSA. The County Office will contact SSA if the individual cannot obtain the necessary verification.

* 4. Income - Countable income cannot exceed 200% of the Federal Poverty Level. Income will be determined according to LTC guidelines (Re. MS 3340-3348).

Effective 4/1/97, the QDWI countable income limit will be:

Individual	$1,315.00
Couple	$1,768.33

5. Resources - Countable resources cannot exceed twice the SSI resource limit. Effective 7/1/90, the QDWI resource standards will be:

Individual	$4,000
Couple	$6,000

Resources will be determined according to LTC guidelines (RE. MS 3330-3337). There will be no penalty imposed for transfer of resources.

6. Social Security Enumeration - the individual must meet the Social Security Enumeration requirements specified in MS 1358.

7. Citizenship or Alien Status - the individual must meet the citizenship/alien status requirement specified in MS 3324.

8. Residency - the individual must be an Arkansas resident (Re. MS 2200).

9. Mandatory Assignment of Rights to Medical Support/Third Party Liability (Re. MS 1350).

10. Not Otherwise Eligible for Medicaid - the individual will not be eligible as a QDWI if eligibility can be established in any other Medicaid category.

Each eligibility factor will be verified by the Service Representative and documented in the case narrative.

2048.4 Income Determination

The income of an ineligible spouse will be deemed to the QDWI applicant (Re. MS 2111-2111.5) and the net income compared to the couple's QDWI limit.

The income of an eligible couple will be totaled, and SSI exclusions will be given (only one $20 exclusion). The net income for the couple will be compared to the couple's QDWI income limit.

The income of QDWI's may vary monthly due to their income from employment. MS 3343 will be utilized in the determination and verification of earnings from employment.

2048.5 Initial Enrollment Period (IEP) and General Enrollment Period for Medicare Part A

A QDWI applicant must reenroll for Medicare Part A, if he/she has not previously reenrolled prior to making application.

The Social Security Administration will send notices to those individuals who lost or will lose Medicare Part A solely due to SGA, advising them to contact the SSA office. Once reapplication has been made for Medicare Part A, SSA will refer potentially eligible individuals to the County Office to make a QDWI application.

If an individual applies at the County Office prior to reenrolling for Medicare Part A, the individual will be instructed to go to the SSA Office to reenroll for Medicare Part A and provide verification of reenrollment and the effective date of coverage.

The Individual Enrollment Period begins with the month in which the individual receives notice from SSA that his/her entitlement to Disability and Medicare will end solely due to SGA. The enrollment period ends 7 months later.

There will also be a General Enrollment Period each year from January 1 - March 31.

2048.6 Disposition and System Procedures

Approval:

If all eligibility factors have been met, and the case is approved, the Service Representative will perform the following tasks:

a. Complete Form EMS-57 for a Category 41 on WASM. When certifying an eligible couple, each will be entered on a separate EMS-57. The case will be entered in closed "C" status. An Action Type of "AF" or "BF" will be used with the appropriate Action Reason.

b. An "N" will be entered in the Client Notice Field.

c. A "9" must be entered in the Lock-in Indicator Field to identify QDWI recipients.

d. The Medicaid Begin Date will be based on the date of the application and the date on which all eligibility factors are met, including the effective month of Medicare Part A. QDWI eligibility can be effective up to 3 months prior to the date of application, if all eligibility factors were met during that 3 month period, but in no case can eligibility begin prior to July 1, 1990.

   For example, an individual applies for QDWI benefits on September 1, 1994, and the effective month of Medicare Part A is August. This individual's QDWI benefits could begin August 1, 1994.

   If, however, the individual has not reenrolled for Medicare Part A prior to making application, and his Medicare Part A entitlement will not be effective until October 1, 1994, QDWI benefits cannot be effective prior to 10/01/94.

5. Social Security Enumeration Requirement (MS 1358).

6. Resource Requirement - Countable resources may equal but cannot exceed twice the current SSI resource limitations:

Individual	$4,000
Couple	$6,000

Resources are determined according to Long Term Care guidelines (MS 3330 - 3337). No penalty will be imposed for transfer of resources.

7. Income Requirement - Countable income must be greater than (but not equal to) 100% of the current Federal Poverty Level, and less than (but not equal to) 120% of the current Federal Poverty Level (see note below).

Effective 4/1/97 these levels are:

	100%	120%
Individual	$657.50	$ 789.00
Couple	$884.17	$1,061.00

The LTC guidelines at MS 3340-3348 will be applied when determining countable income. The Supplemental Security Income Exclusions at MS 3348 will be given. Inkind Support and Maintenance will be considered, if applicable.

For couples, their combined net countable income, after all disregards and exclusions, will be compared to the couple's standard in determining the eligibility of each member of the couple. In determining eligibility for only one member of a couple, the procedures for deeming of income at MS 2111 - 2111.5 will apply.

Note: In determining eligibility each year between January 1st and April 1st for SMB applicants, the Social Security Cost of Living Adjustment (COLA) for the year will be disregarded until April 1st, i.e., an individual's or couple's SSA amount to be considered in the budget will be the amount for the previous year. The current year's SSA amounts will not be considered until April first when the new Federal Poverty Level Income limits become effective (Re. MS 2051.5).

2051.4 Period of Eligibility

A. Medicaid Begin Date

The beginning date of eligibility for payment of the Medicare Part B Premium will be the first day of the month following the month of SMB certification (i.e. completion of the DCO-57). For example, if an SMB application is certified on August 15th, the effective date of eligibility will be September 1st. Date specific eligibility will not change the effective begin date for SMB recipients.

B. Retroactive Coverage

Medicaid eligibility for SMBs cannot begin earlier than the first day of the month following the month of certification. Retroactive coverage will not be authorized for SMBs. If eligibility is to be established retroactively in another category, all eligibility requirements for that category must be met.

2051.5 Disposition and System Procedures

A. Approval - If all eligibility requirements are met, the application may be approved for SMB. The Service Representative will complete the following tasks:

1. Complete Form DCO-57 for a Category 88 approval and submit for data entry on WASM.

2. The Medicaid Begin Date entered on WASM will be the first day of the month following the month of certification.

3. In Field 49 on Form DCO-57, a unit size of one (1) will be entered for an individual applicant. For a couple, whether both members apply or not, a unit size of two (2) will be entered.

4. The current income will be entered in the appropriate fields. The total SSI exclusions will be entered in the Unearned Exclusion field, and a "Y" entered in the MU field. The current 120% FPL amount will be entered in the MNIL field. The net income will be entered in the Net Countable field. There must be a deficit of at least $.01 in the Deficit/Excess field.

5. Code Form DCO-87 for a yearly reevaluation or anticipated change.

6. Notify client of approval by Form DCO-700 or DCO-55.

B. Denial - If the applicant does not meet all the eligibility requirements, the application will be denied. The County Office Worker will complete the following tasks:

1. Record pertinent information in case narrative to verify the denial decision.

2. Complete denial data on DCO-777.

3. Notify applicant of denial by DCO-700 or DCO-55.

C. Withdrawal - If the applicant wishes to withdraw the application, a signed statement must be obtained from the applicant stating that he wishes to withdraw the application. The County Office Worker will then proceed with the steps for denying the application.

185% Federal Poverty Level (4/1/97)

Number in Standard	Monthly Standard
1	$1,216.38
2	1,635.71
3	2,055.04
4	2,474.38
5	2,893.71
6	3,313.04
7	3,732.38
8	4,151.71

Add $419.33/month for each additional member.

Note: The FPL is adjusted annually due to changes in the Consumer Price Index. For continuing eligibility, the average monthly gross income, as computed above, will be compared to the FPL in effect during the report month, if different from the preceding months.

If the family's average gross monthly earnings (less paid child care) do not exceed 185% of Federal Poverty Level, the family will remain eligible. The case will be documented.

If the family's average gross monthly earnings (less paid child care) exceed 185% of the FPL, the County will send a notice of closure to the family, and will key a closure to the Transitional Medicaid case on WATM and WACE with a Medicaid End Date effective the last day of the report month. Earnings that resulted in Transitional Medicaid closure will be entered in the budget section. Night Edit will convert all open members in category 25 to closed status.

2062.4 Changes in the Transitional Medicaid Period

Minor children entering the household, who were not in the budget group at the time the group became AFDC ineligible, will not be eligible for Transitional Medicaid and will not be added to the case. If an excluded child has earnings, they will not be considered in computing the family's average gross monthly earnings. The Service Representative will determine eligibility for this child in another category, counting only the child and the child's parent(s) in the unit, and considering only their income.

Minor children, who were in the home and included in the AFDC grant during the last month of AFDC eligibility, who later leave the home, will be dropped (a 10 day notice will be given). If he/she subsequently reenters the home while the family is receiving TM, he/she will be added to the Transitional Medicaid case. Any earnings that this child may have will be considered in computing the family's average gross monthly earnings.

The return of an absent parent to the home during Transitional Medicaid is not, in itself, a reason for closure (i.e., deprivation is not an eligibility factor for Transitional Medicaid). The absent parent who returns, if he/she was not in the budget group at the time of AFDC case closure, will not be eligible for Transitional Medicaid and will not be added to the case. Any earnings of the absent parent, however, will be used in computing the family's average gross monthly earnings.

If the only child in the home becomes eligible for SSI, the parent(s) (or non-parent specified relative) will remain eligible for Transitional Medicaid as long as the SSI child is under age 18. However, the County will receive a Systems Action Report notifying them that the case has been closed. The Service Representative will reopen the Transitional Medicaid case for the adults(s) by using a "B" action type and "096" action reason. The Transitional Medicaid Status on WATM will be changed to open status. The adult(s) must continue to meet all other eligibility requirements in order to remain eligible for Transitional Medicaid.

2062.5 System Closures, System Reports, and County Responsibilities

On the first workday of each month the system will search all Transitional Medicaid records for children who will reach the age of 18 that month. If the only child in the home is reaching age 18, the system will close the case and send a notice of case closure to the family. If there are other children under 18 in the home, the system will close only the 18 year old and leave the remaining individuals open.

The Counties will receive a Systems Action Report that will inform them of Transitional Medicaid 18 year olds and cases closed by the system.

When the system has closed an 18 year old, or at any time a member or a case is found ineligible for Transitional Medicaid, the County Office will make a determination and document the case record as to whether or not the ineligible member(s) meets the eligibility criteria in any other Medicaid Category (e.g., PW, MN-SD, etc.). If it appears that a member or the case would be eligible in another category, an application and notice of potential benefits will be sent to the individual(s).

The system will continue to close cases becoming AFDC ineligible due to the loss of the 1/3, or $30 earned income exclusions. A system notice will be generated to inform the individuals of Transitional Medicaid eligibility, and these cases will be converted by the system to Category 25 for Transitional Medicaid. These cases will also be listed on the Systems Action Report.

During the Additional 6 Months TM Extension Period (Second Six Months), a monthly report titled "Transitional Medicaid Cases" will be generated to the Counties to assist them in tracking the Transitional Medicaid cases. This report will list the Case Number, Casehead Name, Worker Number, Transitional Medicaid Begin Date, Current Month of Transitional Medicaid and the next month in which a Transitional Medicaid Report (DCO-124) is due.

At the end of the 12th month, the system will send a notice and close all Transitional Medicaid cases which remained open throughout both 6 month periods.

2062.6 Summary of Sequence of Notices/Reports in Transitional Medicaid

Found AFDC ineligible prospectively. Determined Transitional Medicaid eligible:

- Form DCO-123 manually issued to family.

Initial 6 months Extension Period

1st Month

- 1st month of AFDC ineligibility.

* Monthly Standards (4/1/97)

Number in Standard	133% - PW/Children Under age 6	100% - Children ages 6 and up
1	$ 874.48	$ 657.50
2	1,175.95	884.17
3	1,477.40	1,110.83
4	1,778.88	1,337.50
5	2,080.35	1,564.17
6	2,381.80	1,790.83
7	2,683.28	2,017.50
8	2,984.75	2,244.17
9	3,286.22	2,470.84
10	3,587.69	2,697.51
For each additional person add,	$301.47	$226.67

5740 Periods of Eligibility

5740.1 Pregnant Woman Eligibility Period - Retroactive, "No Look Back" and Post partum Coverage

SOBRA eligibility for a pregnant woman may begin at any time during a medically verified pregnancy, and will be extended through the end of the month in which the 60th day postpartum falls. A PW who applies postpartum and is found SOBRA eligible in the month of delivery will be given the full postpartum coverage.

In determining eligibility for the PW, the worker must inquire if the PW had any medical bills of her own (paid or unpaid) in the 3 months prior to the date of application and, if so, determine retroactive eligibility for the retroactive period (there must be medical bills to give retroactive coverage and the medical bills must be verified - the bills must be for the PW - medical bills for other family members will not qualify the PW for retroactive PW coverage); if retroactive coverage is not given, the case record should be clearly documented to show that coverage was considered and why it was not given.

In conjunction with consideration of the retroactive coverage, if an applicant is found eligible in any of the 3 retroactive months, certify the case effective the earliest retroactive month of eligibility; there will be a "No Look Back" at later income increases, throughout the pregnancy and the postpartum period, even if the applicant is not income eligible in the month of application or in the month in which the 45th day of the application falls.

Example: Mrs. Smith applies for SOBRA coverage on November 1, and is not income eligible in November or in December (the month, in which the worker is ready to dispose of the application). However, Mrs. Smith was income eligible and had incurred medical bills in August, September and October. The County will certify Mrs. Smith for SOBRA coverage effective on the date of the earliest bill incurred during the retroactive period (but not more than 3 months prior to the date of application), and will not "look back" at her eligibility again (i.e., disregard the income increase that made her ineligible in November, the month of application).

When the PW is eligible, the full postpartum coverage must be provided, as mandated by law. Based on the expected date of delivery given by the PW, begin counting 60 days on the calendar, with the delivery date as day one; the end of Medicaid coverage will be the last day of the month in which the 60th day falls.

Example: Mrs. Jones' expected delivery date is November 15, and the 60th day after November 15th is January 13th. Coverage will be given through January 31st.

The client will be given the responsibility of reporting a premature delivery or delayed delivery.

5740.2 Infant/Child Eligibility Period

SOBRA eligible infants/children born after September 30, 1983, will remain eligible through the end of the month of their birthday, as specified below, as long as they remain income and resource eligible and as long as they reside with their parent(s), or other specified relatives (Re. FA 2250 - 2252). Children born prior to October 1, 1983, are not eligible under SOBRA.

If an infant/child is an inpatient on his/her birthday, as specified below, eligibility will continue until the end of the inpatient stay, provided the infant/child remains income and resource eligible. (Infants/children with severe disabilities will be referred to Social Security for SSI determination).

Application made after termination of a pregnancy does not prohibit coverage for the infant/child, i.e., a mother need not be a certified Medicaid recipient at the infant's birth in order for the infant/child to receive SOBRA coverage, as specified below. A mother need not remain Medicaid eligible in order for the infant/child to qualify for continuing coverage.

1. Children Up To Age Six - Children up to their sixth birthday will be covered at 133% of the Federal Poverty Income Guidelines.

2. Children Ages Six and Older - Coverage for children ages six and older, born after September 30, 1983, will be provided and extended as follows. Beginning:

October 1, 1990 - Eligibility may continue up to the eighth birthday;

October 1, 1991 - Eligibility may continue up to the ninth birthday;

October 1, 1992 - Eligibility may continue up to the tenth birthday;

October 1, 1993 - Eligibility may continue up to the eleventh birthday;

October 1, 1994 - Eligibility may continue up to the twelfth birthday;

October 1, 1995 - Eligibility may continue up to the thirteenth birthday;

October 1, 1996 - Eligibility may continue up to the fourteenth birthday;

October 1, 1997 - Eligibility may continue up to the fifteenth birthday;

October 1, 1998 - Eligibility may continue up to the sixteenth birthday;

October 1, 1999 - Eligibility may continue up to the seventeenth birthday;

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

[ ] Policy [X] Form [ ] Policy Directive

Issuance Number IMF 97-4

Issuance Date 04-01-97

Income Maintenance Forms Manual

Expiration Date Until Superseded

From: Roy Hart
Director

Subj: Revised Form

Form to be Deleted,	Dated	Form to be Added,	Dated
DCO-62	4/96	DCO-62	4/97

Summary of Changes

The DCO-62 has been revised to reflect 133% of the 1997 Federal Poverty Levels. This form is used as the income eligibility guideline for Pregnant Women whose presumptive eligibility is determined by Qualified Providers. These levels will be effective 4/1/97.

The form will be available for ordering on or after March 24, 1997. Forms currently in stock should be destroyed and should not be used after March 31, 1997. A supply of the form should be kept in stock for Qualified Providers.

Inquiries to: Terri Wright, 682-8258
Ann Dawson, 682-8254
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Arkansas Department of Human Services
Presumptive Eligibility Budget Sheet

Name of Applicant _____ County of Residence _____

Primary Screening Questions

	Yes	No
1. Do you have a current Medicaid Card? If yes, stop here.	☐	☐
2. Are you self-employed?	☐	☐
3. Is either parent of the unborn child not a U.S. citizen?	☐	☐
4. Are you living with a man that is not the father of the unborn child?	☐	☐
5. Are you living with a man that is the father of the unborn child and you are married to someone else?	☐	☐

If the patient answers "yes" to any of questions 2 through 5 do not complete the presumptive eligibility packet. Give the patient an Application (DCO-95), a Checklist for Medicaid Applicants and encourage her to go to the local Department of Human Services for eligibility determination.

If the patient answers "no" to all of the above questions, continue with Presumptive Eligibility:

Income Guidelines

Family Unit Size	Monthly Standard
2	$ 1175.95
3	1477.40
4	1778.88
5	2080.35
6	2381.80
7	2683.28
8	2984.75
9	3286.22
10	3587.69

If a family unit exceeds 10, add $301.47 per mo. for each additional member.

Total Number Included in the Unit (include unborn child(ren) _____

1. Total Monthly **Earned** income (before deductions) for Unit. Do not include income for household members that are not a part of the Unit. **EXCEPTION:** Count income of the parent(s) of under age 18 pregnant woman. $ _____

   Subtract $90 for Each Employed Member of the Unit. - $ _____

2. Subtract Child Care Paid Each Month (For full-time and part-time employees, up to $175 per child age 2 and older, up to $200 per child under age 2.) - $ _____

   $ _____

   Total Net Earned Income

3. Total monthly **UNEARNED** Income for the Unit (VA, SSA, contributions, etc.) Do not include income of household members who are not part of the Unit. **EXCEPTION:** Count income of parent(s) of the under age 18 pregnant woman. $ _____

4. Subtract Unearned Income Deductions ($50 month child support, etc.) - $ _____

   Total Net Unearned Income + $ _____

5. Add Total Net Earned Income and Total Net Unearned Income

   Total Net Income For The Unit $ _____

Compare the Total Net Unit Income with the Monthly Standard from the Income Guidelines. Does the Applicant Meet the presumptive Eligibility Requirement? ☐ Yes ☐ No

I certify that the above named applicant has a medically verified pregnancy and that, based on this preliminary budget information, she qualifies for presumptive eligibility in the SOBRA PW category.

Her expected date of delivery is _____

Check One:
- ☐ ADH
- ☐ AHEC
- ☐ CHC

Authorized Signature	Date of P.E. Determination	Location

DCO-62 (R.4/97)

Purpose

To screen patients for possible presumptive eligibility. To figure total net income for those included in the unit, certify medically verified pregnancy, and establish presumptive eligibility.

Used By

ADH/AHEC/CHC and Department of Human Services.

Explanations and Definitions

Name of Applicant:	Self-explanatory.
County of Residence:	Self-explanatory.
PRELIMINARY SCREENING QUESTIONS	
Question 1-5:	Check appropriately.
Total Number In the Unit:	Number determined according to policies/procedures for figuring unit size.
Complete steps 1 and 2 and enter amounts as applicable.	Enter N/A if not applicable.
Total Net Earned Income:	Amount as determined in steps 1 and 2. If none, enter N/A.
Complete steps 3 and 4 and enter amounts as applicable.	Enter N/A if not applicable.
Total Net Unearned Income:	Amount as determined in steps 3 and 4. If none, enter N/A.
Complete step 5 and enter in blank for Total Net Income for the Unit.	
Does the Applicant Meet the Presumptive Eligibility Requirements?	Check appropriately.
Check the appropriate box to indicate which agency completed the P.E. determination.	
Authorized Signature:	Person completing presumptive eligibility determination must sign.
Date of PE Determination:	Self-explanatory.
Location:	Town where PE determination was made.