

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

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CEI			
CASE NUMBER	CIN/RID NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS				
+--- +--	---+ ---+			
GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP				
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

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

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 +-+ ACCEPT your presumptive eligibility application for Medicaid coverage effective from _____ to _____ pending verification of information in your application.

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

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