Alabama Medicaid Hospital Presumptive Eligibility Application

Instructions: To find out if the patient can get Hospital Presumptive Eligibility (HPE), please ask the patient to answer all the questions on this form. This is a voluntary program. All information is confidential. HPE gives patients temporary coverage. If the patient is pregnant, services are limited to ambulatory prenatal and pregnancy-related care only. The patient must fill out a full Alabama Medicaid application to get continued coverage.

Last Name First Name Middle Name (Jr. Sr. II. etc.)

Date of birth *(month/date/year)* Social Security Number (*optional)* Male Female

☐ If homeless, check the box & tell us where we can reach you**.**

Home Address *(number & street)* City State ZIP Code

Mailing Address (if different than above) City State ZIP Code

Living in Alabama? ☐Yes ☐No US Citizen or Qualified Non-Citizen? ☐Yes ☐ No

County living in? _____

Best contact phone number Other phone number Email address

What language does the patient speak best? What language does the patient read best?

1. Does the patient have an Alabama Medicaid Card? ☐Yes ☐No

If yes, what is the identification number on the card (if available)? _____

2. Is the patient a parent of a child or caretaker relative of a child that lives with the patient? ☐Yes ☐No

3. Was the patient in Foster Care at 18 years old, and is now under 26 years old? ☐Yes ☐No

4. Is the patient pregnant? ☐ Yes ☐ No

If yes, when is the expected due date? _____ How many babies expected (if known) _____

Note: *If the patient is pregnant, services are limited to ambulatory, prenatal and pregnancy-related coverage only.*

How many family members live in the patient's household? _____

(*Include parent, spouse, and any children under age 21 living in the household)*

How much is the patient's household income?

$ _____Monthly or $ _____Yearly

I certify that I have read and understand this Alabama Medicaid pre-enrollment application. I understand that I must complete the Alabama Medicaid application before the last day of the following month my Alabama Medicaid pre-enrollment application is approved to continue my coverage. I declare that the information I provided is true, correct, and complete.

Signature of patient or parent/spouse/guardian/emancipated minor Relationship to patient *(if applicable)* Date