Hospital Presumptive Eligibility Statement of Interest

Please indicate if your organization is interested in becoming a hospital presumptive eligibility determination site for the [State agency's] Hospital Presumptive Eligibility Program. Indicating your interest does not obligate you to, preclude you from, or guarantee participation in the Hospital Presumptive Eligibility Program.

Hospital Name: _____

Contact Name, Phone, E-mail: _____

- ❑ Yes, we are interested in becoming a hospital presumptive eligibility determination site.
- ❑ No, we are not interested in becoming a hospital presumptive eligibility determination site.

Please complete this form and return to [State agency] by [date].

E-mail:
Fax:
Mailing address:

Please contact [Contact name] with any questions.

E-mail:
Phone:

Comments or Questions

Qualified Entity Application for Hospital Presumptive Eligibility

This is an application to become a Qualified Entity for Hospital Presumptive Eligibility for the purposes of offering Presumptive Eligibility to your patients. ***You must participate as a Medicaid provider to perform Hospital Presumptive Eligibility determinations.*** Please complete, sign, and return this application to [State agency].

If you have questions about this application or the Hospital Presumptive Eligibility program, contact [State agency] at: [phone number] or [email address].

1. Name of hospital	
Other name (if any used for provider services)	2. County
Telephone number ( )	FAX number ( )
3. Mailing address (no P.O. Box) for Site	City
4. Contact person	
Telephone number ( )	FAX number ( )
5. Please estimate the number of patients your hospital sees each month that are not covered by health insurance or Medicaid at the time of their visit.	

I hereby certify that all the above information is true and accurate to the best of my knowledge.

Signature	Title of Authorized Agent	Date

Hospital Presumptive Eligibility (HPE) Qualified Entity Responsibilities and Agreement

I understand the responsibilities as a HPE Qualified Entity include:

- Offering the HPE program to patients without health coverage or Medicaid;
- Screening interested patients for income eligibility via the prescribed PE forms and guidelines;
- Informing patients at the time of the HPE determination that they must file a Medicaid application in order to obtain regular Medicaid coverage beyond the PE period;
- Attesting that all individuals performing HPE are direct employees of the entity and do not work as contractors or vendors of the hospital;
- [Assisting patients in completing an application for Medicaid or subsidized insurance through the state's marketplace or healthcare.gov, if needed];
- Providing with the HPE determination notice a written statement to applicants informing them that they may file a regular Medicaid application regardless of eligibility for PE;
- Notifying the [state agency] within five working days with the required information on those patients eligible for HPE;
- Attending HPE training and keeping current with changes affecting HPE through provider bulletins, notices and/or further training.

I, (print name) _____, agree to cooperate with [state agency] in complying with the above Qualified Entity responsibilities. I am aware that if I do not comply with these responsibilities and the PE guidelines as outlined in [state agency manual/regulations], I may lose status as a Qualified Entity. I agree to notify the [State Agency] in writing of any changes in application information at least [10] days prior to the effective date of the change.

Signature	Title of Authorized Agent	Date

Simplified Hospital Presumptive Eligibility Qualified Entity Agreement

_____

Hospital Name

Hospital agrees:

1. To determine presumptive eligibility in accordance with [state's name] Medicaid regulations and guidelines as promulgated by [state agency name overseeing hospital PE].
2. To participate in random quality assurance reviews conducted by [state agency conducting review] and to take any corrective action necessary as a result of the review.

Failure to meet any of the above conditions may be cause for termination of this agreement and may result in the hospital's disqualification from the hospital presumptive eligibility program.

_____ _____

Date Signature of Authorized Agent

_____

Authorized Agent Name and Title