



PRESUMPTIVE ELIGIBILITY (PE) APPLICATION ONLY

This application is used for Presumptive Eligibility (PE) determinations for:

- Children (HMK *Plus* and HMK) • Former Foster Care Children, ages 18 up to 26 • Parent/Caretaker Relative Medicaid
- Pregnant Woman • Breast & Cervical Cancer • Individuals between the ages of 19-64

For ongoing coverage, applicants may:

- <http://www.healthcare.gov> /or phone 1-800-318-2596
- [Apply online at www.apply.mt.gov](http://www.apply.mt.gov) or phone 1-888-706-1535
- Apply by mail using a paper **Application for Health Coverage**. Mail application to: P.O. Box 202925, Helena, MT 59620-2925

Applicant Information – Please PRINT CLEARLY.

First Name:	Last Name:
Home Address:	City/State/ZIP:
Mailing Address (if Different):	City/State/ZIP:
Home or Cell Phone:	Message Phone:

Household Information -- Complete for every person living in the household. List adults first, then children. Social Security Numbers are requested **but are not required**. *U.S. Citizenship and *Qualified Non-Citizen status **ONLY** need to be included for persons applying for Presumptive Eligibility. ****Answer ONLY for HMK.**

Name (First – Middle Initial – Last)	Relationship to Applicant	Apply for PE? (Y/N)	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender (M/F)	*U.S. Citizen (Y/N)	<u>SEE PAGE 3 ADDENDUM</u> *Qualified Non-Citizen (Y/N)	Montana Resident (Y/N)	**Has Health Insurance (Y/N)
1	<u>(self)</u>								
2									
3									
4									
5									
6									

Is anyone in the household pregnant? ____Yes ____No **If “Yes”, who?** _____ Date Due _____ How many unborns? ____
 Was anyone in Foster Care and receiving Medicaid at age 18? ____Yes ____No **If “Yes”, who?** _____

Household Income Information

Earned Income -- List this MONTH’S total gross wages before taxes for each person; **Unearned Income** -- List all monthly unearned income (i.e., Unemployment, Social Security, Pensions, Interest/Dividends) for each person. **(Do not include Child Support or Worker’s Comp)**

(Please Print)

First Name	Earned Income Total	Unearned Income Total	TOTAL (Monthly Gross)

COMBINED TOTAL MONTHLY GROSS INCOME = \$ _____

Community Engagement (CE) Requirements Attestation and Applicant Signature

This section should only be completed for individuals aged 19-64 with a household income at or under the ACA adult income limit for their household size as referenced in the [Current Income Calculation Tool](#).

CE Exclusion Attestation Statement (if applicable) – Check the exclusions that apply to you at the time of application.

I, _____, confirm that (check one or more):

- I am American Indian, Alaska Native, or California Indian
- I am eligible for services through Indian Health Services
- I am a former foster child under 26 years of age and I was in foster care when I turned 18
- I am an inmate of a public institution
- I have a medical condition or health needs that impact ability to work or do other community engagement activities (*check one below*)
 - I am blind or disabled, as determined under section 1614 of the Social Security Act
 - I have a substance use disorder (SUD) where I have not been in stable recovery for 5 or more years — for example, alcohol, opioid, or stimulant use disorder
 - I have a disabling mental disorder — for example, schizophrenia, moderate or severe bipolar disorder, major depressive disorder, or panic disorder
 - I have a physical, intellectual, or developmental disability that significantly impairs my ability to perform one or more activities of daily living (ADLs) — for example, cerebral palsy, muscular dystrophy, spinal cord or brain injury, or Down syndrome

- I have a serious or complex medical condition — for example, cancer, end-stage renal disease, COPD, HIV/AIDS, heart disease, ALS, Parkinson's disease, or multiple sclerosis*
- I am a parent, guardian, caretaker relative, or family caregiver of a dependent child under age 14 or a disabled individual
- I am a participant in an alcohol or drug addiction treatment program
- I am pregnant or postpartum (12 months or less)
- I am a veteran with a disability rated as total (*rating of 100%*)
- I am eligible for Medicare
- I was recently incarcerated in the last three months
- I require necessary travel for medical services not available in the community for a serious medical condition
- I am an individual receiving inpatient or institutional services

CE Qualifying Activities Attestation Statement (if applicable) – If no exclusions apply, check the qualifying activities that you completed in the month prior to application.

I, _____, confirm that I have completed at least 80 hours of one or a combination of the below activities in the month prior to application (check one or more):

- Work** — working a job where you receive income or are compensated in-kind
- Community service or volunteering** — community service with a not-for-profit organization with a valid Tax ID
- Workforce training or job readiness programs** — participating in a work program approved by DPHHS, including activities provided and tracked by the Department of Labor & Industry
- Internships or registered apprenticeships** — unpaid work, participating in a program approved by DPHHS.
- Going to school** — enrolled in an institution of higher education, career and technical education program, or high school/GED program

(Applicant OR Parent/Guardian/Other) – I understand the questions on this application and the penalty for withholding or giving false information. I certify, under penalty of perjury, all my answers are correct and complete to the best of my knowledge. I understand the information provided on this application can be used to establish identity for children under age 16.

Applicant Name _____ **Applicant Signature** _____
 (Please Print)

(Presumptive Eligibility may last 60 days or less and is limited to once every 365 days OR once/pregnancy).

FOR OFFICE USE ONLY – Qualified Entity must complete all information below:

COMBINED TOTAL MONTHLY GROSS INCOME for Household: \$ _____** **Household Size** _____

(**Compare this amount to the Income Calculation Tool for the appropriate category of applicant(s) based on household size, then finalize determination).

DATE DETERMINED (mm/dd/yyyy) _____ **Facility** _____

QE Signature _____ **QE Name (print)** _____

QE Phone _____ **QE FAX** _____ **QE Email** _____

**Within 5 days of Determination, SCAN application AND Proof of Temporary Coverage form, then [create a secure ePass account at transfer.mt.gov](#), and <mailto:hhs presumptive@mt.gov?subject=Presumptive Eligibility Application Submittal>
OR FAX same documents to: 1-877-418-4533**



Presumptive Eligibility Application Addendum for Qualified Non-Citizens

ALL PERSONS WHO ARE IMMIGRANTS NEED TO REVIEW THE FOLLOWING INFORMATION TO DETERMINE IF THEY ARE A QUALIFIED NON-CITIZEN; THEN THEY SHOULD MARK THE APPROPRIATE RESPONSE ON PAGE 1.

Those who are in ANY of the following groups would be considered a Qualified Non-Citizen:

- Lawful Permanent Residents (LPR/Green Card Holder)** -- SEE FURTHER INFORMATION, BELOW
- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Children lawfully residing in the state of Montana (lawfully present and otherwise eligible for Medicaid or HMK in the state, including being a state resident)

****In order to get Medicaid coverage, under current law most ADULT Lawful Permanent Residents or green card holders have a 5-year waiting period. This means they must wait 5 years after receiving “qualified” immigration status before being eligible for Medicaid. There are also exceptions -- Lawful Permanent Residents who don’t have to wait 5 years -- such as people who used to be refugees or asylees.**

Montana has removed the 5-year waiting period to cover lawfully residing children who are otherwise eligible for Medicaid or HMK. A child is “lawfully residing” if lawfully present and otherwise eligible for Medicaid or HMK in the state (including being a state resident).

NOTE: Immigrants who are qualified non-citizens are generally eligible for Medicaid and Children’s Health Insurance Program (HMK) coverage IF they are otherwise eligible for Medicaid and HMK in the state; that is, if they meet Montana’s income eligibility rule.

