Patient Record # ________________
Date Care Initiated ______________

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Eligible ________ Ineligible __________

PRESUMPTIVE ELIGIBILITY DETERMINATION FORM FOR PREGNANCY – RELATED CARE

Patient Information: Address ____ County ____________ Phone ____________ E-Mail ______________

Street Address City State Zip

Health Insurance Information:

Company Name	Policy Holder's Name	Policy Number	Group Number	Insurance Type(s) *	Policy Begin Date

*Types:

Major Medical	Basic Hospital/Surgical	Basic Hospital	Dental Only	Cancer Only	Accident Only
Indemnity	Nursing Home Only	Medicare Supplement	Intensive Care	Physician Only	Major Medical+Dental
Prescriptions Only	Vision Care	Heart Attack Only	Hospital Outpatient Only	Major Medical+Nursing Home	

Line No.	FAMILY MEMBERS								Monthly Gross Income				Monthly Net Income				
	First	MI	Last	DATE OF BIRTH Month Day Year	Sex	Race	Ethnicity	Social Security No. Not required for non-applicant	Type	Amt.	Freq.	Gross Monthly Amt.	EITC	Std.Work Deduction	Child Care	Child/Spousal Support Excl.	Countable Monthly Income

Total Gross Income =	Sub-Total =
No. In Family =	Child/Spousal Support Paid =
Poverty Income Level =	Total Family Net Income =

The federal government requires the State to provide information about your language preference. Please help us by providing the language you prefer to speak (circle one)

English Spanish Other (Specify________________________)

I understand that this is a temporary determination of my eligibility for Medicaid and that I must file an official application for Medicaid by the last day of the month following the month this form is signed or my eligibility will stop on that date. I also understand that I am eligible only for care related to my pregnancy. I certify that I have provided true and accurate information about my family and income.

__________________ ________________________________
Application Date Applicant's Signature

__________________ ________________________________ __________________
Date Completed Completed By Title

Provider Certification:
I certify that the woman for the presumptive determination of eligibility has been made is approximately ______ weeks pregnant with ______ fetus. Her expected delivery date is ___________.

________________________________ ________________________________
Signature Title

________________________________ ________________________________
Provider Provider Number

DMA-5032 (06/13)
PS-00252

INSTRUCTIONS FOR PROVIDER:

I. General
   A. Use black ink.
   B. Complete 3 copies.
   C. Mail or deliver to the County DSS of the applicant's county of residence no later than 5 working days after the presumptive determination.

II. Patient information
   A. Provide requested information on health insurance coverage for the pregnant women only. If the woman states she has no insurance, write NONE. If space is needed for more than three policies, attach additional sheet.
   B. Give the pregnant woman's current mailing address.
   C. Whenever possible, obtain patient's telephone number and/or e-mail address.
   D. Patient record no. is for the use and convenience of the provider.
   E. Give the date prenatal care was initiated for this pregnancy.
   F. Indicate the name of the county to which the DSS referral will be sent.
   G. Document whether patient was determined eligible or ineligible for presumptive eligibility.

III. Family members – Must be living in the home or absent for a temporary period.
   A. Enter family members names in the following order:
      1. Pregnant woman
      2. Pregnant woman's husband if he is not receiving Work First, SSI or CAP.
      3. Children of the pregnant woman and/or her husband, who are under age 21, have never been married, have never served in the military, are not receiving Work First, Supplemental Security Income (SSI), special needs adoption assistance (IAS), foster care assistance (HSF) or Community Alternatives Program (CAP), or are not legally emancipated.
   B. Birth date of the pregnant woman is required. Optional for other family members.
   C. Enter sex code for each member.
   D. Enter race code for each member.
   E. Enter ethnicity code for each member.
   F. Enter the pregnant woman's social security number. Copy from her social security card if available. Social security numbers are not required for non-applicants.
   G. Enter relationship of all family members to the pregnant woman.

IV. Monthly Gross Income
   A. For the pregnant woman and her husband if living in the home or temporarily absent.
      1. Enter code for type of income; see codes below.
      2. Enter gross amount income as received.
      3. Enter code for frequency of receipt; see frequency codes below.
      4. If a family member receives more than one type of income, mark out the line no. of a blank line and write in family member's line no. Enter income information.
   B. Convert each type income to a monthly amount; see conversion formulas below. Record monthly amount in "Gross Monthly Amt." Column.
   C. Total family income; enter in "Total Gross Income" block.
   D. Record number in family.
   E. Record Poverty Income Level for number in family in designated block; see chart below. If Total Gross Income is equal to or less than Poverty Income Level for number in family - STOP. Pregnant woman is presumptively eligible.

V. Monthly Net Income
   A. For persons with wages/salary enter:
      1. The standard $90 each in "Std. Work Deduction" column.
      2. Any Earned Income Tax Credit (EITC), state or federal.
      3. The monthly amount paid for childcare or incapacitated adult care (up to $175 per person or $200 for a child under 2) into the "Child Care" column.
      4. Subtract these amounts from gross wages/salary and enter the resulting amount in the "Countable Monthly Income" column.
   B. For any person who receives child/spousal support:
      1. Enter in the "Child/Spousal Support Excl." column the amount of child/spousal support received.
      2. Subtract $50.00 from the gross monthly amount of child/spousal support.
      3. Enter the resulting amount in the "Countable Monthly Income" column.
   C. For other types of income enter the gross monthly amount in the "Countable Monthly Income" column.
   D. Total the family's Countable Monthly Income & enter in the "Sub-Total" block.
   E. If the pregnant woman or her husband pays court ordered child/spousal support, enter the monthly amount actually paid in "Child/Spousal Support Paid" block.
   F. Subtract the Child Support Paid from the Sub-Total. Enter the resulting amount into the "Total Family Net Income" block.
   G. If Total Family Net Income is equal to or less than Poverty Income Level, the pregnant woman is presumptively eligible.

VI. Signatures
   A. Obtain the pregnant woman's signature and date of signature.
   B. A medical professional must complete the medical verification of the pregnancy.
   C. The person completing the DMA-5032 must sign and enter the date presumptive eligibility determined.

VII. Enter provider's name and provider's ID number.

VIII. CODES

TYPE OF INCOME		RACE	ETHNICITY	Frequency Codes (Conversion Formula)
W- Wages	A- Alimony	W-White	N-Not Hispanic/Latino	W-Weekly (4.3)
S- Salary	CS-Child Support	B- Black or African American	U-Unreported	B-Bi-weekly (2.15)
P- Pension	C- Contributions	I- American Indian or Alaska Native	C-Hispanic Cuban	S-Semi-Monthly (2)
F- Farm, Self-Employed	MA-Military Allotment	A- Asian	H-Hispanic Other	M-Monthly (2)
SS- Social Security Benefits	T- Trusts, Estates	P- Native Hawaiian or other Pacific Islander	M-Hispanic Mexican American	A-Annually (Divide by 12)
RR- Railroad Retirement	O- Other	U- Unreported	P-Hispanic Puerto Rican	
VA- Veterans Benefits	I- Interest, Dividends, Insurance, Annuities			
UC- Unemployment Ins.				
WC-Worker's Comp.				