# **APPLICATION FOR PRESUMPTIVE ELIGIBILITY FOR MEDICAID**

**Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid.** Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage. **This coverage will include coverage for coronavirus (COVID-19) testing and treatment costs.**

To find out if you qualify for regular Medicaid or other health coverage, you must complete CNMI’s Medicaid application. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through presumptive eligibility for Medicaid.

|  |  |
| --- | --- |
| **Who can qualify for presumptive eligibility for Medicaid?**  | You can qualify for presumptive eligibility for Medicaid if you meet all of these rules: * Your income is below the monthly limit
* You do not already have Medicaid
 |
|  |  |

To find out what kinds of coverage you are eligible for through this application, make sure to follow instructions regarding which sections are necessary for you to complete.

To see if you are eligible for other health care benefits and services through Medicaid, you should submit a complete application to the CNMI Medicaid Office in Capitol Hill.

# **STEP 1: CONTACT INFORMATION**

*One adult in the family should be the contact person. The contact person does not have to be applying for coverage.*

|  |
| --- |
| 1. Name *(first, middle, last)*
 |
| 1. Home Address *(leave blank if you don’t have one)*
 | 1. City
 | 1. State
 | 1. Zip
 |
| 1. Mailing Address *(if different from home address)*
 | 1. City
 | 1. State
 | 1. Zip
 |
| 1. Phone Number
 | 1. Email address
 |
| 1. Preferred written language
 | 1. Preferred spoken language
 |

# **STEP 2: TELL US ABOUT YOU AND YOUR FAMILY**

*List yourself and the members of your immediate family who live with you. Include your spouse and your children if they live with you. Do not list other relatives or friends even if they live with you.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name (first, middle, last) | Date of birth (xx/xx/xxxx) | Relationship to you | Applying for coverage? (Yes or No) | Already has Medicaid? (Yes or No) *Only answer this for family members who are applying.* |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |
| 8. |  |  |  |  |

# **STEP 3: TELL US ABOUT YOUR FAMILY’S INCOME**

*Write the total income before taxes are taken out for all family members listed in STEP 2.*

|  |
| --- |
| Job income *For example, wages, salaries, and self-employment income*Amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? (Check one) [ ]  Weekly [ ]  Biweekly [ ]  Monthly [ ]  Yearly |
| Other income *For example, unemployment checks, alimony (do not include as part of your income alimony received under a separation or divorce agreement finalized or revised on 12/31/2018 or later),* *or disability payments from the Social Security Administration (“SSDI”). Do not include Supplemental Security Income (“SSI payments”) or any child support you receive.* Amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? (Check one) [ ]  Weekly [ ]  Biweekly [ ]  Monthly [ ]  Yearly |
| Total income *Add up the job income and other income you entered above*Amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? (Check one) [ ]  Weekly [ ]  Biweekly [ ]  Monthly [ ]  Yearly |

**STEP 4: SIGNATURE:** *By signing, you are swearing that everything you wrote on this form is true as far as you know. We will keep your information secure and private.*

|  |  |
| --- | --- |
| Signature | Date |

# **If you qualify for presumptive eligibility for Medicaid, what happens next?**

* You will get a notice from your doctor or other provider saying you were approved.
	+ **You can start using your presumptive eligibility for Medicaid coverage right away** for Medicaid covered services such as doctor visits, hospital care, and some prescription drugs. You can go to any health care provider who accepts Medicaid, starting the day you are approved.
	+ To start using your presumptive eligibility for Medicaid, CHCC will give you a notice saying you are approved. If you lose the notice, you can call CHCC’s CARA office at 670-234-8950, ext 3502.

# **If you do not qualify for presumptive eligibility for Medicaid, what happens next?**

# You will get a notice from CHCC saying you were not approved. You cannot appeal the provider’s decision. BUT, you can still apply for regular Medicaid using the CNMI Medicaid application or other health coverage.