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].

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1. Name of hospital

   Other name (if any used for provider services)

2. County

   Telephone number 
   
   FAX number
   
   City

3. Mailing address (no P.O. Box) for Site

   City

4. Contact person

   Telephone number 
   
   FAX number
   
   City

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.

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

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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.

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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