GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES
Department of Human Services
"Working Together to Make a Difference"

MEDICAID PROGRAM

Hospital Application for Presumptive Eligibility for Medicaid

1 Tell us about yourself (*Primary household member*)

Gender: ☐ **Male** ☐ **Female**

We ask for this information so that we can contact you about this application.

Name *(first, middle, last)*

Social Security Number (SSN) (Not required for PE determination)

Date of Birth (MM/DD/YYYY)

Home address *(Indicate "NONE" if you do not have one)*

City, State, Zip code

Mailing address *(if different from home address)*

Phone number *(if you have one)* Email address *(if you have one)*

2 Tell us about your family

List the members of your immediate family who live with you. Include your spouse and your children under *age 19* if they live with you. Do not list other relatives or friends even if they live with you.

Name *(first, middle, last)*	D.O.B. (MM/DD/YYYY)	Social Security Number (SSN) (Not required for PE determination)	Relationship to you	Already has Medicaid? (Yes or No)	Applying for PE? (Yes or No)	U.S. Citizen, U.S. National, or eligible immigrant? (Yes or No)	Resident of the Territory? (Yes or No)

3 Other questions

Answer these questions for yourself and any family members listed in Section 2. Your answers will make it easier to find out if you and any family members qualify.

Is anyone pregnant, even if she is not applying for presumptive eligibility for Medicaid? ☐ **Yes** ☐ **No**

If yes, who? ....

Expected due date? .... **How many babies does she expect?** ....

Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative? ☐ **Yes** ☐ **No**

For example, a grandparent who is the main person taking care of a child.

If yes, who? ....

Is anyone who is applying for presumptive eligibility a former foster care child who is currently under the age of 26?

☐ **Yes** ☐ **No** **If yes, who? ....**

What age did the claimant leave the foster care system? ....

Was the Claimant enrolled on Medicaid at the time they aged out? ☐ **Yes** ☐ **No**

4 Tell us about your family's income

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

Job income *For example, wages, salaries, and self-employment income.*

Amount $.................. Employer/Address...

How often? *(check one)* ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly Hours .... Date began ....

Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do not include any child support you receive.

Amount $.................... Type of **B**enefit ....

How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly Date began ....

5 Sign this form here (optional)

We will keep your information secure and private.

Your signature (optional):	**Date:**
Hospital Representative Signature	Date: