ATTACHMENT VI

NOTICE OF DECISION ON YOUR PRESUMPTIVE MEDICAID ELIGIBILITY
APPLICATION FOR COVERAGE OF NURSING FACILITY SERVICES OR INPATIENT HOSPICE CARE

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CEI
CASE NUMBER / CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPI

This Department has made a decision concerning your Medicaid presumptive eligibility application dated _____. We are sending this notice to tell you that this Department will:

+-+
+-+ ACCEPT your presumptive eligibility application for Medicaid coverage effective from _____ to _____ pending verification of information in your application.

Please note that Medicaid does not cover hospital-based clinic services, hospital emergency room services, acute hospital inpatient services (except when provided as part of hospice care), and bedhold during the presumptive eligibility period. We have calculated the total monthly contribution toward the cost of this individual's care for the periods indicated:

From _____ To _____		From _____ To _____	
Gross Monthly Income	$_____	Gross Monthly Income	$_____
Deductions	- _____	Deductions	- _____
Net Monthly Income	$_____	Net Monthly Income	$_____
Income Allowance		Income Allowance	
Personal Needs		Personal Needs	
Allowance/MA Level	-$_____	Allowance/MA Level	-$_____
Contribution to		Contribution to	
Community Spouse	- _____	Community Spouse	-_____
Family Member		Family Member	
Allowance(s), or		Allowance(s), or	
Dependent Household		Dependent Household	
Member(s)	- _____	Member(s)	- _____
Costs of Medical/		Costs of Medical/	
Remedial Care	- _____	Remedial Care	- _____
Remaining Available		Remaining Available	
Monthly Income	= _____	Monthly Income	= _____
Contribution from		Contribution from	
Spouse	+ _____	Spouse	+ _____
Restricted Income	+ _____	Restricted Income	+ _____
Total Income		Total Income	