PRESUMPTIVE ELIGIBILITY HOSPITAL Patient information form

Socia	Security Number	This per	son does not have a social security number			
Name	:					
	Last Name	First Name	Middle Initial			
Date of Birth:		Age	Male Female			
	l Status (check one): Singl ☐ dowed ☐ Living Together Par		orced Separated Legally Separated ☐ ☐ Gogether ☐ Married Living Apart			
	s this person a resident of Kent is this person a US Citizen? Race: Is this person of Hispanic, Latin Ethnicity: Preferred Written Language sthis person currently pregnan if yes, how many children is this What is the due date? (mm/dd/y) Has this person received Presur Would this person like to be refers this person currently incarcer if yes, when did this person enter	ucky?	this pregnancy? pregnancy? ☐ Yes ☐No ☐No			
 Is this person a parent caretaker for any child in the household? Yes No Has this person ever been in foster care? Yes No If yes, what state? Did this person get healthcare through this state's Medicaid program? Yes No How old was this person when he/she left the foster care system? 						
• 1	What date should benefits begin?					
Addre	_					
Street Address		Apt/Building Nu	ımber			
City		State Zip	Code			
Count						
Teleph	none Number(s):					
•	• •					

How many family members does this person have?
When calculating family size, include the patient, any unborn child/children, dependent children
and spouse. If patient is living with parents and under age 19, count parents, step-parent and
siblings under 19 in the household size.

FAMILY INCOME

Whe

	Family Member's Name	Income Type*	How Much?	How Often
1				
2				
3				
4				
	TOTAL MONTHLY INCOME:			

Home/Cell Telephone Number Work Telephone Number other

Count income of the patient, spouse and parents' income (if the patient is living with parents and claimed as a tax dependent). Include gross wages (before taxes) and other sources of income such as social security, pensions, alimony, cash gifts, and annuities. Do not count child support or SSI (Supplemental Security Income). Do not count income of dependent children (whether or not they live in the home).								
OTHER INSURANCE Does this person currently have insurance that covers doctors, office visits, and hospitalization? ☐ Yes ☐ No								
If "Yes" What is the name of this plan		Name						
of Insurance Co. Poli	cy No. Group	No.						
Preferred MCO: Anthem Blue Cross/Blue Shield Aetna Humana CareSource Passport Health Plan WellCare United Health Care Primary Care Physician								
I certify, under penalty of perjury, the information provided by me in this statement is correct and true to the best of my knowledge. I understand that anyone who gives false information in order to receive benefits, or lets someone else use their PE card or abuses PE benefits is subject to criminal action under federal law, state law or both or may be liable for repaying in cash the value of the benefits received.								
Patient Signature	Date Signed							