PRESUMPTIVE ELIGIBILITY PREGNANCY
Patient information form

Social Security Number ___________________ ☐ This person does not have a social security number

Name: ____
Last Name First Name Middle Initial

Date of Birth: ________________________ Age _____________ ☐Female

Marital Status (check one): ☐ Single-Never Married ☐ Divorced ☐ Separated ☐ Legally Separated

☐ Widowed ☐ Living Together Partner ☐ Married Living Together ☐ Married Living Apart

- Has this person received Presumptive Eligibility benefits for this pregnancy? ☐ Yes ☐No
- Is this person a resident of Kentucky? ☐ Yes ☐No
- Is this person a US Citizen? ☐ Yes ☐No
- Race: _________________ Nationality: ________________________
- Is this person of Hispanic, Latino, or Spanish origin? ☐ Yes ☐No
- Ethnicity: ______________________
- Preferred Written Language ☐ English ☐Spanish
- Would this person like to be referred for WIC? ☐ Yes ☐No
- Is this person currently incarcerated? ☐ Yes ☐No
- If yes, when did this person enter prison? (mm/dd/yyyy) _________________
- What date should benefits begin? __________________________

Address:

____
Street Address Apt/Building Number

____
City State Zip Code

____
County

Telephone Number(s):

____
Home/Cell Telephone Number Work Telephone Number other

Whe

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

Expected due date (mm/dd/yyyy) ____

FAMILY INCOME

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

Count income of expectant mother and spouse. Parents' income (if expectant mother 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 with expectant mother).

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. Policy No. Group No.

____

Preferred MCO:
☐ Anthem Blue Cross/Blue Shield ☐ CoventryCares ☐ Humana CareSource
☐ Passport Health Plan ☐ WellCare
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*