

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

How many family members does this person have? _____

When calculating family size, include the expectant mother, any unborn child/children, dependent children living in the home, and spouse. If the expectant mother is living with parents and under age 19, count the 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 the income of the expectant mother, spouse, and parents' income (if the 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, 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 the 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 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