## PRESUMPTIVE ELIGIBILITY HOSPITAL
### 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 _____ ☐ Male ☐ 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 this calendar year? ☐ 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
- Is this person currently pregnant? ☐ Yes ☐ No

- If yes, how many children is this person expecting from this pregnancy? _____
- What is the due date? (mm/dd/yyyy) _____
- Has this person received Presumptive Eligibility for this pregnancy? ☐ Yes ☐ No
- 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) _____
- 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? _____

- 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 patient, any unborn child/children, dependent children and spouse. If the patient is living with parents and under age 19, count parents, step-parent and siblings under 19 in the household size.

FAMILY INCOME

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

*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. Policy No. Group No.

_____

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 actin 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* _____